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HEALTH SECURITY ACT—MEDICAL MALPRACTICE PROVISIONS

HEARING BEFORE THE SUBCOMMITTEE ON ECONOMIC AND COMMERCIAL LAW OF THE COMMITTEE ON THE JUDICIARY HOUSE OF REPRESENTATIVES ONE HUNDRED THIRD CONGRESS

SECOND SESSION

ON

H.R. 3600

TO ENSURE INDIVIDUAL AND FAMILY SECURITY THROUGH
HEALTH CARE COVERAGE FOR ALL AMERICANS IN A MANNER
THAT CONTAINS THE RATE OF GROWTH IN HEALTH CARE COSTS
AND PROMOTES RESPONSIBLE HEALTH INSURANCE PRACTICES,
TO PROMOTE CHOICE IN HEALTH CARE, AND TO ENSURE AND
PROTECT THE HEALTH CARE OF ALL AMERICANS

JUNE 22, 1994

Serial No. 61



Printed for the use of the Committee on the Judiciary

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HEALTH SECURITY ACT—MEDICAL MALPRACTICE ISSUES

WEDNESDAY, JUNE 22, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON ECONOMIC AND COMMERCIAL LAW,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:07 a.m., in room 2141, Rayburn House Office Building, Hon. Jack Brooks (chairman of the subcommittee) presiding.

Present: Representatives Jack Brooks, John Conyers, Jr., Mike Synar, Patricia Schroeder, Dan Glickman, Howard L. Berman, Robert C. Scott, David Mann, Hamilton Fish, Jr., Elton Gallegly, Charles T. Canady, Bob Inglis, and Carlos J. Moorhead.

Subcommittee staff present: Cynthia W. Meadow, counsel; Perry Apfelbaum, assistant counsel; Catherine S. Cash, research assistant; and Deloris L. Cole, office manager; full committee staff present: Jonathan R. Yarowsky, general counsel; Alan F. Coffey, minority chief counsel; and Roger T. Fleming, minority counsel; also present: Bryan Frazier and Michael McGown, Interns.

OPENING STATEMENT OF CHAIRMAN BROOKS

Mr. BROOKS. The committee will come to order. Today the subcommittee holds its second hearing on the Health Security Act, focusing on medical malpractice issues.

Since President Clinton submitted his ambitious plan for reforming one-seventh of the American economy, three committees in the House and two in the Senate have been absorbed in comprehensively reviewing, rethinking, rewriting it.

As I indicated during last week's hearing, the Judiciary Committee's jurisdiction over the bill, while not as expansive, nevertheless holds crucial implications for the ultimate success of any health care reform initiative and the future well-being of the American people.

Without question, the proper functioning of the medical malpractice system is one of the most important safeguards against substandard medical care. The ability of victims to bring lawsuits in cases of medical malpractice achieves two important goals: It permits the victim to receive just and adequate compensation for harm suffered, and it serves as a deterrent against future substandard conduct.

The State-governed tort system has evolved gradually over the centuries. In the past, when State laws were perceived as unfairly favoring one side over another, the laws tended to correct them-

selves, either through case law development or by statutory change within the States.

As a result of this dynamic in the States, we in Congress must be extremely careful in reviewing so-called malpractice reform proposals that would unilaterally preempt State law.

Nevertheless, it is essential that we approach these issues with an open mind to empirical information from either side that provides hard and compelling evidence about the need and effect of proposed legislative changes.

But, given the breadth of change proposed by some, I think we need to be careful about opting for radical surgery on the basis of anecdotal evidence.

The subcommittee is fortunate to have a distinguished group of witnesses before us today to help us consider the medical malpractice issues in health care. We welcome you all. The subcommittee looks forward to your testimony.

This morning I am asking the private sector witnesses to appear at the witness table as a panel to testify on the medical malpractice provisions in H.R. 3600. To save time, we will ask each witness to summarize his statement within about 5 minutes.

After the witnesses have completed their statements, the subcommittee will address questions to all of the panel. All of your prepared statements, every pristine word, will be made part of the printed record. Without objection, the hearing record will remain open to receive written testimony from persons who have requested their statements be made a part of this printed record.

Our first witness will be Mr. Corboy and we will go into a description of the witnesses and welcome them after we have some opening statements by some of the members of the subcommittee. Mr. Carlos Moorhead had requested that he be given the first opportunity, if that is all right. Carlos Moorhead, the gentleman from California.

[Selected portions of the text of the bill, H.R. 3600, follow:]

103D CONGRESS
1ST SESSION

H. R. 3600

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 20, 1993

Mr. GEPHARDT (for himself, Mr. BONIOR, Mr. HOYER, Mr. FAZIO, Mrs. KENNELLY, Mr. LEWIS of Georgia, Mr. RICHARDSON, Mr. DINGELL, Mr. ROSTENKOWSKI, Mr. FORD of Michigan, Mr. WAXMAN, Mrs. COLLINS of Illinois, Mr. STARK, Mr. WILLIAMS, Mr. CLAY, Mr. BROOKS, Mr. MOAKLEY, Mr. ABERCROMBIE, Mr. ACKERMAN, Mr. ANDREWS of Maine, Mr. BARRETT of Wisconsin, Mr. BERMAN, Mr. BILBRAY, Mr. BLACKWELL, Mr. BORSKI, Mr. BROWN of California, Ms. BROWN of Florida, Mr. CARDIN, Mr. CLYBURN, Mr. COYNE, Mr. DE LUGO, Ms. DELAURO, Mr. DEUTSCH, Mr. DICKS, Mr. DIXON, Mr. DURBIN, Mr. EDWARDS of California, Mr. ENGEL, Ms. ENGLISH of Arizona, Ms. ESHOO, Mr. FALEONAVAEGA, Mr. FILNER, Mr. FLAKE, Mr. FOGLIETTA, Mr. FRANK of Massachusetts, Mr. GEJDENSON, Mr. GIBBONS, Mr. HASTINGS, Mr. HILLIARD, Mr. HINCHEY, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. JOHNSTON of Florida, Mr. KANJORSKI, Mr. KREIDLER, Mr. LaFALCE, Mr. LANTOS, Mr. LEVIN, Ms. LONG, Mr. MARTINEZ, Mr. MATSUI, Ms. MCKINNEY, Mrs. MEEK, Mr. MINGE, Mrs. MINK, Mr. MURPHY, Mr. MURTHA, Ms. NORTON, Mr. OBERSTAR, Mr. OBEY, Mr. OWENS, Mr. PASTOR, Mr. PAYNE of New Jersey, Mr. RAHALL, Mr. RANGEL, Mr. REYNOLDS, Mr. ROMERO-BARCELÓ, Mr. RUSH, Mr. SABO, Mr. SAWYER, Mr. SCOTT, Mr. SERRANO, Ms. SHEPHERD, Mr. SKAGGS, Ms. SLAUGHTER, Mr. SMITH of Iowa, Mr. STOKES, Mr. STRICKLAND, Mr. STUDDS, Mr. SWIFT, Mr. SYNAR, Mr. THORNTON, Mrs. THURMAN, Mr. TRAFICANT, Mr. UNDERWOOD, Mrs. UNSOELD, Mr. VENTO, Mr. WATT, Mr. WHEAT, Mr. WISE, and Mr. YATES) introduced the following bill; which was referred jointly to the Committee on Energy and Commerce, to the Committee on Ways and Means, and to the Committee on Education and Labor for consideration of such provisions in titles I, III, VI, VIII, X, and XI as fall within its jurisdiction pursuant to clause 1(g) of rule X; and concurrently, for a period ending not later than two weeks after all three committees of joint referral report to the House (or a later time

if the Speaker so designates), to the Committee on Armed Services for consideration of subtitle A of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(c) of rule X, to the Committee on Veterans' Affairs for consideration of subtitle B of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(u) of rule X, to the Committee on Post Office and Civil Service for consideration of subtitle C of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(o) of rule X, to the Committee on Natural Resources for consideration of subtitle D of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(n) of rule X, to the Committee on the Judiciary for consideration of subtitles C through F of title V and such other provisions as fall within its jurisdiction pursuant to clause 1(l) of rule X, to the Committee on Rules for consideration of sections 1432(d), 6006(f), and 9102(c)(5), and to the Committee on Government Operations for consideration of subtitle B of title V and section 5401

A BILL

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

1 *Be it enacted by the Senate and House of Representa-*
 2 *tives of the United States of America in Congress assembled,*

3

1 SECTION 1. SHORT TITLE; TABLE OF TITLES AND SUB-
2 TITLES.

3 (a) SHORT TITLE.—This Act may be cited as the
4 “Health Security Act”.

Subtitle D—Medical Malpractice

PART 1—LIABILITY REFORM

SEC. 5301. FEDERAL TORT REFORM.

(a) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in section 5302, this part shall apply with respect to any medical malpractice liability action brought in any State or Federal court, except that this part shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

(2) PREEMPTION.—The provisions of this part shall preempt any State law to the extent such law is inconsistent with the limitations contained in such provisions. The provisions of this part shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this subtitle, places greater limitations on the amount of attorneys' fees that can be collected, or otherwise imposes greater restrictions than those provided in this part.

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1 (3) EFFECT ON SOVEREIGN IMMUNITY AND
2 CHOICE OF LAW OR VENUE.—Nothing in this part
3 shall be construed to—

4 (A) waive or affect any defense of sov-
5 ereign immunity asserted by any State under
6 any provision of law;

7 (B) waive or affect any defense of sov-
8 ereign immunity asserted by the United States;

9 (C) affect the applicability of any provision
10 of the Foreign Sovereign Immunities Act of
11 1976;

12 (D) preempt State choice-of-law rules with
13 respect to claims brought by a foreign nation or
14 a citizen of a foreign nation; or

15 (E) affect the right of any court to trans-
16 fer venue or to apply the law of a foreign nation
17 or to dismiss a claim of a foreign nation or of
18 a citizen of a foreign nation on the ground of
19 inconvenient forum.

20 (4) FEDERAL COURT JURISDICTION NOT ES-
21 TABLISHED ON FEDERAL QUESTION GROUNDS.—
22 Nothing in this part shall be construed to establish
23 any jurisdiction in the district courts of the United
24 States over medical malpractice liability actions on

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1 the basis of section 1331 or 1337 of title 28, United
2 States Code.

3 (b) DEFINITIONS.—In this subtitle, the following
4 definitions apply:

5 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
6 TEM; ADR.—The term “alternative dispute resolu-
7 tion system” or “ADR” means a system that pro-
8 vides for the resolution of medical malpractice claims
9 in a manner other than through medical malpractice
10 liability actions.

11 (2) CLAIMANT.—The term “claimant” means
12 any person who alleges a medical malpractice claim,
13 and any person on whose behalf such a claim is al-
14 leged, including the decedent in the case of an action
15 brought through or on behalf of an estate.

16 (3) HEALTH CARE PROFESSIONAL.—The term
17 “health care professional” means any individual who
18 provides health care services in a State and who is
19 required by the laws or regulations of the State to
20 be licensed or certified by the State to provide such
21 services in the State.

22 (4) HEALTH CARE PROVIDER.—The term
23 “health care provider” means any organization or
24 institution that is engaged in the delivery of health
25 care services in a State and that is required by the

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1 laws or regulations of the State to be licensed or cer-
2 tified by the State to engage in the delivery of such
3 services in the State.

4 (5) INJURY.—The term “injury” means any ill-
5 ness, disease, or other harm that is the subject of
6 a medical malpractice liability action or a medical
7 malpractice claim.

8 (6) MEDICAL MALPRACTICE LIABILITY AC-
9 TION.—The term “medical malpractice liability ac-
10 tion” means a civil action brought in a State or Fed-
11 eral court against a health care provider or health
12 care professional (regardless of the theory of liability
13 on which the claim is based) in which the plaintiff
14 alleges a medical malpractice claim.

15 (7) MEDICAL MALPRACTICE CLAIM.—The term
16 “medical malpractice claim” means a claim brought
17 against a health care provider or health care profes-
18 sional in which a claimant alleges that injury was
19 caused by the provision of (or the failure to provide)
20 health care services, except that such term does not
21 include—

22 (A) any claim based on an allegation of an
23 intentional tort; or

24 (B) any claim based on an allegation that
25 a product is defective that is brought against

1 any individual or entity that is not a health
2 care professional or health care provider.

3 **SEC. 5302. PLAN-BASED ALTERNATIVE DISPUTE RESOLU-**
4 **TION MECHANISMS.**

5 (a) **APPLICATION TO MALPRACTICE CLAIMS UNDER**
6 **PLANS.**—In the case of any medical malpractice claim
7 arising from the provision of (or failure to provide) health
8 care services to an individual enrolled in a regional alliance
9 health plan or a corporate alliance health plan, no medical
10 malpractice liability action may be brought with respect
11 to such claim until the final resolution of the claim under
12 the alternative dispute resolution system adopted by the
13 plan under subsection (b).

14 (b) **ADOPTION OF MECHANISM BY PLANS.**—Each re-
15 gional alliance health plan and corporate alliance health
16 plan shall—

17 (1) adopt at least one of the alternative dispute
18 resolution methods specified under subsection (c) for
19 the resolution of medical malpractice claims arising
20 from the provision of (or failure to provide) health
21 care services to individuals enrolled in the plan; and
22 (2) disclose to enrollees (and potential enroll-
23 ees), in a manner specified by the regional alliance
24 or the corporate alliance, the availability and proce-
25 dures for consumer grievances under the plan, in-

1 including the alternative dispute resolution method or
2 methods adopted under this subsection.

3 (c) SPECIFICATION OF PERMISSIBLE ALTERNATIVE
4 DISPUTE RESOLUTION METHODS.—

5 (1) IN GENERAL.—The Board shall, by regula-
6 tion, develop alternative dispute resolution methods
7 for the use by regional alliance and corporate alli-
8 ance health plans in resolving medical malpractice
9 claims under subsection (a). Such methods shall in-
10 clude at least the following:

11 (A) ARBITRATION.—The use of arbitra-
12 tion.

13 (B) MEDIATION.—The use of required me-
14 diation.

15 (C) EARLY OFFERS OF SETTLEMENT.—
16 The use of a process under which parties are
17 required to make early offers of settlement.

18 (2) STANDARDS FOR ESTABLISHING METH-
19 ODS.—In developing alternative dispute resolution
20 methods under paragraph (1), the Board shall as-
21 sure that the methods promote the resolution of
22 medical malpractice claims in a manner that—

23 (A) is affordable for the parties involved;

24 (B) provides for timely resolution of
25 claims;

1 (C) provides for the consistent and fair
2 resolution of claims; and

3 (D) provides for reasonably convenient ac-
4 cess to dispute resolution for individuals en-
5 rolled in plans.

6 (d) **FURTHER REDRESS.**—A plan enrollee dissatisfied
7 with the determination reached as a result of an alter-
8 native dispute resolution method applied under this sec-
9 tion may, after the final resolution of the enrollee's claim
10 under the method, bring a cause of action to seek damages
11 or other redress with respect to the claim to the extent
12 otherwise permitted under State law.

13 **SEC. 5303. REQUIREMENT FOR CERTIFICATE OF MERIT.**

14 (a) **REQUIRING SUBMISSION WITH COMPLAINT.**—No
15 medical malpractice liability action may be brought by any
16 individual unless, at the time the individual brings the ac-
17 tion (except as provided in subsection (b)(1)), the individ-
18 ual submits an affidavit—

19 (1) declaring that the individual (or the individ-
20 ual's attorney) has consulted and reviewed the facts
21 of the action with a qualified specialist (as defined
22 in subsection (c));

23 (2) including a written report by a qualified
24 specialist that clearly identifies the individual and
25 that includes the specialist's determination that,

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1 after a review of the medical record and other rel-
2 evant material, there is a reasonable and meritorious
3 cause for the filing of the action against the defend-
4 ant; and

5 (3) on the basis of the qualified specialist's re-
6 view and consultation, that the individual (or the in-
7 dividual's attorney) has concluded that there is a
8 reasonable and meritorious cause for the filing of the
9 action.

10 (b) EXTENSION IN CERTAIN INSTANCES.—

11 (1) IN GENERAL.—Subject to paragraph (2),
12 subsection (a) shall not apply with respect to an in-
13 dividual who brings a medical malpractice liability
14 action without submitting an affidavit described in
15 such subsection if—

16 (A) the individual is unable to obtain the
17 affidavit before the expiration of the applicable
18 statute of limitations; or

19 (B) at the time the individual brings the
20 action, the individual has been unable to obtain
21 medical records or other information necessary
22 to prepare the affidavit requested pursuant to
23 any applicable law.

24 (2) DEADLINE FOR SUBMISSION WHERE EX-
25 TENSION APPLIES.—In the case of an individual who

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1 brings an action for which paragraph (1) applies,
2 the action shall be dismissed unless the individual
3 submits the affidavit described in subsection (a) not
4 later than—

5 (A) in the case of an action for which sub-
6 paragraph (A) of paragraph (1) applies, 90
7 days after bringing the action; or

8 (B) in the case of an action for which sub-
9 paragraph (B) of paragraph (1) applies, 90
10 days after obtaining the information described
11 in such subparagraph.

12 (c) **QUALIFIED SPECIALIST DEFINED.**—In sub-
13 section (a), a “qualified specialist” means, with respect
14 to a medical malpractice liability action, a health care pro-
15 fessional who—

16 (1) is knowledgeable of, and has expertise in,
17 the same specialty area of practice that is the sub-
18 ject of the action; and

19 (2) is reasonably believed by the individual
20 bringing the action (or the individual’s attorney)—

21 (A) to be knowledgeable in the relevant is-
22 sues involved in the particular action,

23 (B) to practice (or to have practiced within
24 the preceding 6 years) or to teach (or to have
25 taught within the preceding 6 years) in the

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1 same area of health care or medicine that is at
2 issue in the action, and

3 (C) to be qualified by experience or dem-
4 onstrated competence in the subject matter of
5 the case.

6 (d) **SANCTIONS FOR SUBMITTING FALSE ALLEGA-**
7 **TIONS.**—Upon the motion of any party or its own initia-
8 tive, the court in a medical malpractice liability action may
9 impose a sanction on a party or the party's attorney (or
10 both), including a requirement that the party reimburse
11 the other party to the action for costs and reasonable at-
12 torney's fees, if any information contained in an affidavit
13 described in subsection (a) is submitted without reason-
14 able cause and is found to be untrue.

15 **SEC. 5304. LIMITATION ON AMOUNT OF ATTORNEYS' CON-**
16 **TINGENCY FEES.**

17 (a) **IN GENERAL.**—An attorney who represents, on
18 a contingency fee basis, a plaintiff in a medical mal-
19 practice liability action may not charge, demand, receive,
20 or collect for services rendered in connection with such ac-
21 tion (including the resolution of the claim that is the sub-
22 ject of the action under any alternative dispute resolution
23 system) in excess of 33⅓ percent of the total amount re-
24 covered by judgment or settlement in such action.

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1 (b) **CALCULATION OF PERIODIC PAYMENTS.**—In the
2 event that a judgment or settlement includes periodic or
3 future payments of damages, the amount recovered for
4 purposes of computing the limitation on the contingency
5 fee under subsection (a) shall be based on the cost of the
6 annuity or trust established to make the payments. In any
7 case in which an annuity or trust is not established to
8 make such payments, such amount shall be based on the
9 present value of the payments.

10 (c) **CONTINGENCY FEE DEFINED.**—As used in this
11 section, the term “contingency fee” means any fee for pro-
12 fessional legal services which is, in whole or in part, con-
13 tingent upon the recovery of any amount of damages,
14 whether through judgment or settlement.

15 **SEC. 5305. REDUCTION OF AWARDS FOR RECOVERY FROM**
16 **COLLATERAL SOURCES.**

17 The total amount of damages recovered by a plaintiff
18 in a medical malpractice liability action shall be reduced
19 by the amount of any past or future payment which the
20 plaintiff has received or for which the plaintiff is eligible
21 on account of the same injury for which the damages are
22 awarded, including payment under—

23 (1) Federal or State disability or sickness pro-
24 grams;

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(2) Federal, State, or private health insurance programs;

(3) private disability insurance programs;

(4) employer wage continuation programs; and

(5) any other program, if the payment is intended to compensate the plaintiff for the same injury for which damages are awarded.

SEC. 5306. PERIODIC PAYMENT OF AWARDS.

At the request of any party to a medical malpractice liability action, the defendant shall not be required to pay damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on such schedule as the court considers appropriate, taking into account the periods for which the injured party will need medical and other services.

**PART 2—OTHER PROVISIONS RELATING TO
MEDICAL MALPRACTICE LIABILITY**

**SEC. 5311. ENTERPRISE LIABILITY DEMONSTRATION
PROJECT.**

(a) ESTABLISHMENT.—Not later than January 1, 1996, the Secretary shall establish a demonstration project under which the Secretary shall provide funds (in such amount as the Secretary considers appropriate) to one or more eligible States to demonstrate whether substituting liability for medical malpractice on the part of

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1 the health plan in which a physician participates for the
2 personal liability of the physician will result in improve-
3 ments in the quality of care provided under the plan, re-
4 ductions in defensive medical practices, and better risk
5 management.

6 (b) **ELIGIBILITY OF STATE.**—A State is eligible to
7 participate in the demonstration project established under
8 subsection (a) if the State submits an application to the
9 Secretary (at such time and in such form as the Secretary
10 may require) containing such information and assurances
11 as the Secretary may require, including assurances that
12 the State—

13 (1) has entered into an agreement with a health
14 plan (other than a fee-for-service plan) operating in
15 the State under which the plan assumes legal liabil-
16 ity with respect to any medical malpractice claim
17 arising from the provision of (or failure to provide)
18 services under the plan by any physician participat-
19 ing in the plan;

20 (2) has provided that, under the law of the
21 State, a physician participating in a plan that has
22 entered into an agreement with the State under
23 paragraph (1) may not be liable in damages or oth-
24 erwise for such a claim and the plan may not require

1 such physician to indemnify the plan for any such li-
2 ability; and

3 (3) will provide the Secretary with such reports
4 on the operation of the project as the Secretary may
5 require.

6 (c) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated such sums as may be
8 necessary to carry out demonstration projects under this
9 section.

10 **SEC. 5312. PILOT PROGRAM APPLYING PRACTICE GUIDE-**
11 **LINES TO MEDICAL MALPRACTICE LIABILITY**
12 **ACTIONS.**

13 (a) ESTABLISHMENT.—Not later than 1 year after
14 the Secretary determines that appropriate practice guide-
15 lines are available, the Secretary shall establish a pilot
16 program under which the Secretary shall provide funds (in
17 such amount as the Secretary considers appropriate) to
18 one or more eligible States to determine the effect of ap-
19 plying practice guidelines in the resolution of medical mal-
20 practice liability actions.

21 (b) ELIGIBILITY OF STATE.—A State is eligible to
22 participate in the pilot program established under sub-
23 section (a) if the State submits an application to the Sec-
24 retary (at such time and in such form as the Secretary
25 may require) containing—

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1 (1) assurances that, under the law of the State,
2 in the resolution of any medical malpractice liability
3 action, it shall be a complete defense to any allega-
4 tion that a party against whom the action is filed
5 was negligent that, in the provision of (or the failure
6 to provide) the services that are the subject of the
7 action, the party followed the appropriate practice
8 guideline established by the National Quality Man-
9 agement Program under subtitle A; and

10 (2) such other information and assurances as
11 the Secretary may require.

12 (c) REPORTS TO CONGRESS.—Not later than 3
13 months after the last day of each year for which the pilot
14 program established under subsection (a) is in effect, the
15 Secretary shall submit a report to Congress describing the
16 operation of the program during the previous year and
17 containing such recommendations as the Secretary consid-
18 ers appropriate, including recommendations relating to re-
19 visions to the laws governing medical malpractice liability.

SEC. 5005.

5 (d) PUBLIC AVAILABILITY OF INFORMATION IN NA-
6 TIONAL PRACTITIONER DATA BANK ON DEFENDANTS,
7 AWARDS, AND SETTLEMENTS.—

8 (1) IN GENERAL.—Section 427(a) of the Health
9 Care Quality Improvement Act (42 U.S.C.
10 11137(a)) is amended by adding at the end the fol-
11 lowing new sentence: “Not later than January 1,
12 1996, the Secretary shall promulgate regulations
13 under which individuals seeking to enroll in health
14 plans under the Health Security Act may obtain in-
15 formation reported under this part with respect to
16 physicians and other licensed health practitioners
17 participating in such plans for whom information
18 has been reported under this part on repeated occa-
19 sions.”.

20 (2) ACCESS TO DATA BANK FOR POINT-OF-
21 SERVICE CONTRACTORS UNDER MEDICARE.—Section
22 427(a) of such Act (42 U.S.C. 11137(a)) is
23 amended—

24 (A) by inserting “to sponsors of point-of-
25 service networks under section 1890 of the So-

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1 cial Security Act,” after “State licensing
2 boards,” and

3 (B) in the heading, by inserting “RELAT-
4 ED” after “CARE”.

Mr. MOORHEAD. Thank you very much, Mr. Chairman. I am especially pleased that we are focusing today on medical liability issues. For some time, this has been an issue of great interest to my constituents and to me.

Meaningful, bold medical malpractice reform must be a part of any future health care reform bill because malpractice costs are integrally tied to the rising cost of health care. They are linked through increased utilization of services, or "defensive medicine" through increased insurance and legal costs, and, finally, through increased costs for services to the patient. We are wasting precious resources on cases with no merit and we should resolve those cases which are legitimate in more cost effective ways.

Studies estimate the wasted expenses to be conservatively at \$20 to \$25 billion a year. The malpractice system is certainly not the only cause of rising health care costs, but it is a major contributor. I believe that we can make changes that will reduce these costs without jeopardizing protections for true victims.

In my own State of California, we have seen how successful medical malpractice reform efforts can be. In 1975, after tremendous cooperation between all the parties, the State legislature passed "MICRA, the Medical Injury Compensation Reform Act." For 18 years it has successfully confronted serious excesses in the malpractice system while simultaneously providing fair redress for those who have truly suffered from substandard care.

I can tell you that I have talked to many lawyers in California and many people who have been the plaintiffs in malpractice cases. I have received virtually no complaints about the system as it is working there in our State. What the law does is limit the noncompensatory damages to \$250,000, but everyone can collect every penny that they can show in actual damages.

If Congress wanted to implement a system like MICRA, there is already legislation pending to do just that. H.R. 3080, the "Affordable Health Care Now Act," which has about 140 Members of the House cosponsoring, contains the kind of strong malpractice reform provisions I want to see enacted.

I wish that the President's health bill contained stringent malpractice reform like those in H.R. 3080, but it really does not go far enough. However, I am increasingly hopeful that Congress will not miss this opportunity to make real progress in the area. Early last year, members of the Energy and Commerce Committee had an opportunity to talk to the leaders of health care in England, France, and Germany. All of them stated very clearly that a system like they have or like the one that Mr. Clinton is proposing in this country will not work unless you can do something about medical malpractice. It just cannot be put together without doing something very serious in that area.

I look forward to hearing from our witnesses today and I want to thank you, Mr. Chairman, for the courtesy you have shown me. I do have to go to another hearing and I will not be here throughout the entire performance today.

Thank you.

Mr. BROOKS. Mrs. Schroeder, any?

Mr. Bobby Scott.

Mr. SCOTT. No thank you.

Mr. BROOKS. Mr. Fish, the gentleman from New York.

Mr. FISH. Thank you, Mr. Chairman. This morning's hearing will focus the subcommittee's attention on the important and complex problem of medical malpractice.

Our health system is under the microscope both in Congress and in the media. It is a system that clearly is being burdened by a number of cost-driven pressures. One of these "costs" is the threat of liability suits facing medical practitioners and the amounts they are forced to spend to protect themselves against these suits.

The estimate is that medical malpractice premiums now total \$10 billion annually and malpractice insurance premiums for doctors in my own State of New York are among the highest in the Nation. For a doctor specializing in obstetrics in New York State, the average annual medical malpractice premium exceeds \$100,000 per year. New York is losing doctors, in part because of this liability threat, and therefore the quality of health care in our State is threatened.

But malpractice premiums represent only part of this overall medical legal system problem. The estimates are that the costs of "defensive medicine" run from \$20 billion to \$25 billion a year. Furthermore, medical product-related liability costs affecting pharmaceutical manufacturers and those who make medical devices or provide blood or tissue services are likewise impacted by the same liability concerns. And finally, as we move more and more into managed care, the issue of the scope of a third-party payor's liability is a matter of concern.

Naturally, negligent or reckless actions on the part of medical professionals or the manufacturers of medical devices must not be condoned nor ignored. I believe in the traditional standard for legal tort responsibility, i.e., negligence. If a practitioner is shown to act in an unreasonable, unprofessional, negligent manner in a given fact situation, then liability should attach.

But, the fact of the matter is that very few of these cases ever go to trial or are ever really resolved in a definitive "true or false" sense. Most claims are settled out of court irrespective of any finding of fault, so the vast majority of the costs are really the transactional costs.

Mr. Chairman, Congress should seriously look at a number of the reform proposals that have been put forth. These include the use of the alternative dispute resolution mechanism, but these nonjudicial forums should resolve disputes and not merely delay the inevitable court action which would only add further costs. Similarly, we need to adopt a fair and sensible collateral source rule and the modification of joint and several liability with respect to noneconomic damages is another option that Congress should carefully examine. Punitive damages should only be awarded in those cases where it can be proven that the behavior was "wanton, willful, or reckless" in nature. Punitive damages are frequently awarded in these cases when not justified. I am not an advocate of flat dollar "caps" on attorneys' fees, but I do believe that a sliding scale similar to that adopted in California makes sense. Such a scale should be structured so as to encourage lawyers to represent low and medium-income persons. Finally, I believe that peri-

odic payments for damage awards rather than lump sum payments also makes sense.

What government should do is provide a fair legal structure to resolve these disputes—but it should be a legal structure that encourages good medical judgment, not defensive tactics. Government policies should encourage excellence in the practice of medicine and support quality medical research that will continue to better our country and the entire world.

Mr. Chairman, as we proceed this morning, I welcome the comments of any of our witnesses on these suggested changes in our tort system. Of course, I want to welcome all of our witnesses to this hearing this morning, and I greatly appreciate their taking time to share their expertise with us. In particular, I welcome Dr. David Hannan of New York in Wayne County, NY, who is here this morning representing the Medical Society of the State of New York. Dr. Hannan practices in a rural area in upstate New York and is one of the few general practitioners in the State who continues to provide obstetrical services. I am sure his insights will be helpful.

Again, Mr. Chairman, thank you for scheduling these hearings and I look forward to the testimony.

Mr. BROOKS. Thank you very much. Our first witness will be Mr. Philip H. Corboy, chairman of the Committee on Medical Professional Liability for the American Bar Association. He is an attorney in Chicago, where he is a partner with the Corboy & Dimitrio firm. Next we have Mr. Carl Keener, testifying on behalf of the American Board of Trial Advocates. He is with Baker, Silberberg & Keener in Santa Monica, CA.

Our next witness will be Laura Wittkin, executive director of the National Center for Patients' Rights, New York City. Our fourth witness will be Dr. Antonio Falcon—how do you pronounce that?

Dr. FALCON. Falcon, yes, sir.

Mr. BROOKS. He is a family practitioner in Rio Grande City, TX, way down in the valley, and he is here to testify on behalf of the Health Care Liability Alliance, a coalition of health providers. Next will be Dr. Robert B. Keller, orthopedic surgeon and executive director of the Maine Medical Assessment Foundation, a health services research organization in Maine. Today he represents the Physician Payment Review Commission on which he serves as vice chairman. Our final witness will be Dr. David T. Hannan of Newark, NY, affiliated with the Medical Society of the State of New York.

Gentlemen and Ms. Wittkin, we thank you very much for being with us and I will first start with Mr. Corboy. You are recognized, sir.

STATEMENT OF PHILIP H. CORBOY, CHAIRMAN, COMMITTEE ON MEDICAL PROFESSIONAL LIABILITY, AMERICAN BAR ASSOCIATION

Mr. CORBOY. Thank you, Mr. Chairman, and gentlemen. Thanks for the opportunity to present these views of the American Bar Association on professional medical liability.

Surprisingly, let me say on the surface that much of what Mr. Fish has just stated we are in accord with; however, we are not in accord with the manifestation as suggested. We are in favor of

ADR. We are in favor of various aspects of those things which are euphemistically referred to as reform.

I might point out that the American Bar Association, which is a voluntary organization of 350,000 lawyers, is not a Johnny-come-lately to health care. Since 1972, the ABA has been on record in support of legislation that would provide for every American access to quality health care regardless of a person's income.

However, access to the American legal system has also been a fundamental right tracing back to the beginnings of our country, which is well over 200 years old now.

We understand the concerns being expressed about the issue of medical professional liability. The ABA is deeply committed to having a legal system in America that is effective and just and one that protects the rights of plaintiffs and defendants.

Now, in October of 1992, the Congressional Budget Office supplied a study that reported that medical malpractice premiums account for less than 1 percent of the dollars that are spent annually on the Nation's health care.

I am not so sure it is \$10 billion, but I think it is close to \$10 billion, Mr. Fish. I think it is somewhere in the neighborhood of \$9 billion plus. One percent of that is spent on premiums or somewhere in the neighborhood of \$9 billion. Of those \$9 billion, something less than \$2.5 billion is actually spent on the satisfaction and settlement of claims which do not go to the jury, some of which do go to the jury.

This report also concluded that much of the care that is commonly dubbed defensive medicine would probably still be provided for reasons other than concerns about medical malpractice.

Now, I am going to say something that is going to irritate many listeners. I believe that defensive medicine is malpractice. I am not talking about it being malpractice which is a proximate cause for injuries, but I think it is malpractice. If a doctor comes to me and says, I would like to treat you and I think you should have an MRI because you are going to sue me, I am going to change doctors. If a doctor does not have enough security to satisfy his patient/doctor relationship and instead goes out of his way to charge dollars that should not be charged, I respectfully suggest that is not defensive medicine, that is malpractice.

Now, most doctors in this country, thank God, have been very, very capable of supplying the very best of medical care to their patients. They don't call that defensive medicine. They call it good medicine, and I respectfully suggest that the term defensive medicine is a shibboleth.

I don't believe there are any figures anywhere in the world which can verify that some \$15 or \$20 billion is spent on defensive medicine. I think it is a myth.

And there are other reasons for what they call defensive medicine. Some of them have to do with defending themselves in lawsuits. The answer to defending themselves in lawsuits is twofold.

Number one, first of all, don't be negligent, and number two, have malpractice insurance. Malpractice insurance is a deductible item. It is deductible as a business expense. It is rent, and I respectfully suggest that premiums are a part of practicing medicine, just as they are a part of practicing law.

We have supplied a chart to you today which is Appendix C of my written statement which indicates and shows very specifically that those States in this country that have supplied a form of tort reform to the country have not been those States which have had reduced medical care, specifically the top two supplied by a government office, Massachusetts and California, have stringent medical malpractice laws, however, the cost of medical care has not gone down in those States.

With reference to that which is called a cap on damages, a cap on damages really hurts the person who can least afford it. If a housewife or a child who has no loss of earnings loses his or her sight which requires no further medical expenses, loses his or her ability to practice with his or her mind and goes through life with a mind that can do things with no future medical expenses needed, if that person is restricted to some \$250 or any amount of money, obviously they are under compensated.

Yes, the person that is a large wage earner may very well receive part of his compensation, but a housewife that is seriously damaged, to have a restriction is obviously discriminated against if there is a cap. So I respectfully suggest that a cap again is a myth when it comes to proper compensation.

With reference to ADR, the American Bar Association is on record as being in favor of ADR, however, I offer a caution to you. I believe that to have an ADR as a condition precedent to filing a lawsuit is nothing more than an invitation to file a lawsuit.

You cannot get discovery under ADR. You cannot go all the way and get all the information so that a valid claim can be evaluated and have it properly litigated. So if there is to be ADR, I suggest that you place it subsequent to filing the lawsuit.

With reference to periodic payments, the Uniform Periodic Payment Act has specifically included in it no reduction to present cash value either of noneconomic damages or economic damages by way of loss—damages by way of medical expenses or by way of loss of future earnings.

So if the loss of future earnings is \$10 million and it is not to be reduced to present cash value, then there is no objection to having that \$10 million judgment paid out in a periodic fashion because then the person receiving it is getting the true amount of his or her dollars.

However, if the jury is entitled to reduce future damages, whether by medical expenses or by future damages, they have already reduced it to present cash value, which is the law in most States. It is not the law in Alaska and two others, but it is the law in most States.

If you have already reduced those future damages to present cash value and then reduce the judgment to a periodic payment, you have taken two slices of it. You have reduced it twice, which I suggest is not entirely fair.

As far as the collateral source rule is concerned, of course the collateral source rule will cut verdicts and will cut potential settlements, but all you are doing is transferring the responsibility to pay those costs from one insurance company to another.

Many of the people in this country have insurance that pays for their medical bills. If the medical bills are paid, ordinarily, not always, but ordinarily, there is a subrogation right.

If you reduce the judgment or reduce settlement by those amount of dollars which are paid by a rich uncle, i.e., an insurance company, you are cutting out the right of that insurance company to collect the damages that they paid for.

So all you are doing is transferring the right to collect damages or repayment from one insurance company to another.

I might also say that insurance, medical insurance, is oftentimes a result of labor relations. It becomes a part of the compensation paid to many people who work in this country. It is a negotiated right. Now, to have that negotiated right then cut because the premiums paid by a company and not allow recovery of the collateral—of the dollars that are paid by an insurance company, we respectfully suggest is unfair.

With reference to joint and several liability, my experience quite frankly with joint and several liability, and I have it directly from having done the exact same thing in Illinois that I am doing before you this morning is, doctors don't want it. Doctors do not want it. Why? Because doctors, when they get sued, would like to have the defendant along as a potential tortfeasor paying entity and if there is joint and several liability, oftentimes the doctor will be held responsible more than the hospital, and, if that is true, the doctor is going to pay the most serious part of a judgment.

I have talked to doctors all over the country. When you explain to them what joint and several liability is, they don't want it because they might end up paying the full judgment and letting the hospital off the hook.

Now, does it always happen? No, of course not. Also the hospital administrators I have talked to in Illinois—now, maybe they are different in other parts of the world—the hospital administrators are split on this subject. Some would like the doctor along for the litigation ride, some would prefer that some type of mitigation exist in the realm of legislation which would in one way or another modify the present Joint and Several Liability Act.

I think I have discussed most of the matters that—that are in House bill 3600, and I await hearing the other testimony and I await any questions that might be available.

Mr. BROOKS. Thank you very much.

[The prepared statement of Mr. Corboy follows:]



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Statement of
PHILIP H. CORBOY, CHAIR of the
SPECIAL COMMITTEE ON MEDICAL PROFESSIONAL LIABILITY
 on behalf of the
AMERICAN BAR ASSOCIATION
 before the
SUBCOMMITTEE ON ECONOMIC AND COMMERCIAL LAW
COMMITTEE ON THE JUDICIARY
 of the
UNITED STATES HOUSE OF REPRESENTATIVES
 on the subject of
MEDICAL PROFESSIONAL LIABILITY ISSUES AND HEALTH CARE REFORM
 June 22, 1994

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to present the views of the American Bar Association on medical professional liability in the context of proposals to increase access to health care. I am Philip H. Corboy, Chair of the ABA's Special Committee on Medical Professional Liability.

Since 1972, the ABA has been on record in support of legislation that would provide for every American to have access to quality health care regardless of a person's income. In February 1992, and again in February 1994, the ABA's House of Delegates reaffirmed its support of legislation calling for universal coverage for all through a common public or public/private mechanism through which all contribute.

The American Bar Association is concerned about the ability of Americans, including its own members, to obtain affordable health insurance. Health care at a reasonable cost has been an American expectation, and a concept the American Bar Association supports. Likewise, access to the American legal system has been a fundamental right tracing back to the origins of this country.

The ABA understands the concerns being expressed about the issue of medical professional liability and is deeply committed to having a legal system in America that is effective and just, one that protects the rights of plaintiffs and defendants. Two ABA entities worked towards this end by developing recommendations for the ABA's House of Delegates. They are the Special Committee on Medical Professional Liability and the Action Commission to Improve the Tort Liability System.

The ABA Special Committee on Medical Professional Liability was composed of a balanced group of plaintiffs' lawyers, defense lawyers and representatives of academia, and the judiciary. The Committee was chaired by ABA Past-President Talbot S. D'Alemberte, then Dean of the Florida State University College of Law. The Committee was charged with studying legislative initiatives in the medical malpractice area and developing ABA policy proposals for the Association's policymakers to consider. In February 1986, the ABA House of Delegates adopted a resolution upon recommendation of the Committee. (A copy of that resolution is appended to this statement as Appendix A.) The Committee was then disbanded. However, it was reactivated in August 1991.

Near the end of 1985 the ABA, through its President, appointed an Action Commission to Improve the Tort Liability System. The 14-member Commission was asked to develop specific proposals to improve the tort liability system. The members of the Commission were federal trial and appellate court judges; a state Supreme Court justice; corporate counsel, including those with insurance experience; consumer and civil rights advocates; academicians; and practicing plaintiffs' and defense lawyers.

In February 1987, the ABA House of Delegates considered the Commission's recommendations and adopted the resolution appended to this statement as Appendix B. The ABA takes the position that these proposals to improve the tort system can and should be implemented by the courts and legislatures at the state, and not the federal level. The tort system has shown considerable resilience in the face of dramatic social and economic developments. State courts and legislatures are constantly working to improve the tort laws and should be permitted to continue to do so. Thus, federal intrusion into the field, with some discrete exceptions, is inappropriate.

The ABA believes that federal pre-emption of the state medical professional liability laws would constitute an unwise and unnecessary intrusion of major proportions on the long-standing authority of the states to promulgate tort law. Such pre-emption would cause the whole body of state tort law to become unsettled and create new complexities for the federal system. Unequal results would occur when medical professional liability litigation is combined with other fields of law with differing rules of law. An example of this would be a situation where a medical malpractice claim is joined with an automobile liability claim. If state tort laws differ from the federal law in areas such as caps on damages, the collateral source rule or joint and several liability, conflicts and uncertainty would likely result; and one defendant in an action could well be treated entirely differently than another. Having one set of

rules to try medical professional liability cases and another set of rules to try other tort cases is not consistent with the sound and equitable administration of justice.

Our ABA policies reflect the ABA's recognition that the issue of medical professional liability is of vital importance not only to the legal profession but to the medical profession, the insurance industry and, most of all, to the public.

The public has the most at stake in this issue. When a person suffers injury as a result of negligence by a provider of health care services, he or she must have the right to seek recovery for the full measure of those damages. We believe that right is severely threatened by those who call for major changes in this country's tort law system, and particularly by those who propose that limits be placed on the amount of damages persons may seek in compensation for their injuries caused by the negligence, or carelessness of health care providers.

We are especially concerned with proposals to alter the system of medical malpractice to carve out exceptions in the tort law system for one group of potential defendants -- in this case, the medical profession. It is the ABA's belief that the rights of injured persons to recover fully for injuries caused by the wrongful acts of others must be protected. We are concerned that those who seek major changes in the way the tort law system deals with cases of medical malpractice are willing to trade away the rights of all individuals in the hope of easing a perceived burden on some or reducing the overall costs of health care. Since medical malpractice insurance costs make up only a small fraction of the dollars spent on health care in the United States, the changes in the tort laws would have no real impact on costs of health care.

In addressing access to health care proposals, that contain provisions on medical professional liability, three questions need to be asked. First, what is the cost savings that can be achieved? Second, have such provisions, when enacted, lowered health care costs in states which have adopted their essential elements? Third, what are the consequences to the traditional American legal system and to the rights of the injured persons? In other words, does a cost shifting from the medical professional who caused the injuries to the person who was injured or to a governmental agency achieve anything more than an illusory savings?

What is the Cost of the Medical-Legal System?

The American Bar Association does not purport to possess the expertise to analyze all of the reasons for escalating medical costs. We do, however, have the ability to analyze the interrelationship of the legal system and those costs. Moreover, we are able to determine the consequences of proposed legislation upon the American legal system and those seeking compensation for injuries.

The major components that have been cited as contributing to the rising cost of that care are:

- * Reliance on modern, sophisticated and expensive treatment.
- * Innovative treatment of illnesses, such as heart disease, AIDS and cancer;
- * An aging population, which adds to Medicare and Medicaid expenditures;
- * High administrative costs of the health care system; and
- * The medical-legal system.

Studies concerning the medical-legal system show that its impact on the national expenditures is not only questionable but also insignificant. The Congressional Budget Office stated in 1992 that medical-legal costs, as measured by medical malpractice insurance premiums, account for 0.74 percent of the national health expenditures.¹ I understand that these insurance premiums account for a lower percentage of national health expenditures at this point in time. The other component of cost attributed to the legal system is that of so-called "defensive medicine." Varying figures for the cost of "defensive medicine" have been estimated. However, no one has reliably measured what, if anything, defensive medicine costs.

An October 1992 study of the Congressional Budget Office concluded that health care spending is propelled upward by high-cost technological and medical breakthroughs. The study finds that rising incomes, demographic changes, and medical malpractice costs do not appear to account for much of the increase in the nation's health care bill. The report states that malpractice insurance premiums account for less than one percent of the dollars spent annually on the nation's health care.

The report also concluded that "much of the care that is commonly dubbed 'defensive medicine' would probably still be provided for reasons other than concerns about medical malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this 'defensive care' helps to reduce the uncertainty of medical diagnosis, it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform."²

To address the subject of "defensive medicine," there must be agreement upon the meaning of the phrase. However, there is no agreement upon the definition.³ That uncertainty has resulted in the inability to statistically measure the cost.⁴ In published studies, "defensive medicine" has included erroneously the cost of the consequence of physicians' financial incentive to direct patients for tests and examinations in facilities in which physicians have a proprietary interest.⁵ Some have considered the cost of new technology and advancements in medical knowledge, care and treatment. In that regard, patients expect the use of very modern, sophisticated and expensive technology to refine diagnosis and eliminate uncertainties.

Therefore, to examine the impact of the medical-legal system, the necessary inquiry is to what extent physicians direct medical expenses that are unwarranted for the treatment or diagnosis of patients, and are not motivated by personal financial interests. In other words, an expense is only attributable to the medical-legal system when the sole reason for that expense is concern by the physician about a medical malpractice claim. There has been no study to measure that cost, and there appears to be no basis for assuming that competent and reputable physicians impose such expenses upon their patients without a justifiable medical reason.

To the extent that physicians' concern about liability results in more conscientious medical care, then "defensive medicine" is certainly desirable.⁶ When the fear of tort liability deters medical injuries, then health care costs are lowered by avoiding the costs associated with medical injury.⁷ Thus, if liability concerns are a deterrent, provisions that relieve physicians of concern regarding negligent practices can actually result in an increase of health care costs.

Because no reliable studies have been done to estimate the cost of so-called defensive medicine, the Office of Technology Assessment has been asked to study the issue and is expected to complete its study in 1994.

**HAVE TORT PROPOSALS, WHEN
ENACTED, LOWERED OVERALL HEALTH CARE COSTS?**

It is often asserted that caps on noneconomic damages and elimination of the collateral source rule result in lower health care costs for everyone. In general, these types of proposals have been enacted only within the last ten years. Insufficient time has elapsed, and insufficient data has been gathered to enable us to be certain of the impact on costs of these proposals. However, from our research and study it appears that these proposals have not had any measurable impact on overall health costs. In looking into the issue we found that personal health care spending per capita approximately doubled throughout the United States from 1982 to 1990 regardless of whether a state had enacted "tort reforms" and regardless of the type of "reforms" enacted. We developed a chart (attached as Appendix C) showing the percentage of increase from 1982 to 1990 in personal health care spending per capita by state. It is derived from a February 1992 report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences," published by the General Accounting Office (GAO). The GAO report utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF.

As the chart demonstrates, personal health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted.

For example, based on the figures utilized in the GAO report, the three states with percentage increases estimated to be slightly lower than average -- Arkansas, Kentucky and Mississippi -- had no caps on damages in medical malpractice cases. Alabama, with a slightly higher than average estimated percentage increase, had a cap on damages. Massachusetts and California, the two states with the highest estimated personal health care costs per capita, had in place a cap on damages.

Our findings are consistent with other studies. For example, in March 1993, the Coalition for Consumer Rights published False Claims: The Relationship Between Medical Malpractice "Reforms" and Health Care Costs. This study found there to be "no indication that enacting major tort 'reforms' is positively correlated with lower health care costs." In fact, the study found that "states with the lowest per capita expenditures are more likely to have enacted fewer tort 'reforms' overall than the average." Regarding caps on damages, the Coalition's study concluded as follows:

- 7 -

Since the medical establishment has made caps on damages its single highest priority, we would expect to see some correlation between states which have limits on recovery and inexpensive health care. However, only 30% of the ten states spending the least in health care have enacted limits on recovery of damages; 55% of the remaining 40 states have such a statute. A closer examination of the states ranked by spending shows that there is no correlation between the least expensive states and limits on damages.

Our findings are consistent with previous research we have conducted on the "health care savings" of caps. Indiana has one of the most restrictive caps laws in the nation, and yet a 1992 survey of hospital bed costs and delivery charges in comparable cities in Illinois and Indiana revealed that the small variance in fees could not be attributed to lower medical malpractice costs coming from caps on awards.

A 1992 study funded by the Texas Medical Association, the Texas Trial Lawyers Association and the Texas Hospital Association reported that its findings indicated that "changing the medical professional liability system will have minimal cost savings impact on the overall health care delivery system in Texas.

The cost of medical malpractice insurance, for the most part, reflects the cost of the medical-legal system. In contrast to the increase in health care costs, medical malpractice costs have been relatively stable in recent years.¹⁰ The number of medical malpractice claims peaked in 1985, and has continued to decline according to the most current figures available. From 1985 to 1990, the overall rate declined at an average annual rate of 8.9 per cent.¹¹

WHAT ARE THE CONSEQUENCES TO THE PUBLIC OF PROPOSALS TO CAP NONECONOMIC DAMAGES OR ELIMINATE THE COLLATERAL SOURCE RULE IN MEDICAL MALPRACTICE CASES?

Proposals of this type are ill-advised. Elimination of the collateral source rule solely favors medical professionals by passing on the cost of the medical injury to another health care provider. Often, an insured person has the benefit of health or disability insurance which pays for a portion of the additional medical costs attributable to the injuries caused by a physician's negligence. Typically, the insurer will assert a

lien against its insured's recovery or pursue a subrogation claim. Under proposals to eliminate the collateral source rule, the negligent physician would get a credit for the insurer's payment, and the insurer could not recover from the person who injured its insured. An obvious consequence of the loss of lien and subrogation rights by a health or disability insurer will be an increase in those premiums. Where government proposals provide such insurance, government health care costs would increase. The net result is no reduction in health care costs but a windfall benefit to the defendant medical professional and his or her insurer at the expense of the injured person.

Proposals to limit noneconomic damages deprive individuals of compensation for the consequences of medical malpractice injuries. No one has stated that such injuries are not real or severe. In fact, noneconomic injuries may far exceed the economic damages. These proposals, if enacted, would make seriously injured persons who are the least able to afford it receive less than full compensation while less seriously injured persons would be fully compensated. This would be grossly unjust.

A bottom line is whether the economic benefits to the public in reducing health care cost is significant enough to warrant depriving other members of the public -- injured persons -- of full and adequate compensation from those responsible for their injuries. With the cost of the entire medical-legal system constituting less than one percent of health care costs, a pertinent inquiry is whether such proposals would have any noticeable impact except upon injured persons.

Such proposals would not eliminate the less than one percent of health care costs attributable to medical professional liability since no one seriously urges that the medical profession should be immune from liability. Rather, such proposals are directed at those injured persons who are ultimately compensated. These victims of medical negligence are the subject of such proposals. Any savings in the cost of health care would be a small fraction of a percent. Thus, even on an economic analysis, such proposals, if implemented, will not have a measurable impact upon the cost of health care. Such proposals, however, would impact severely and dramatically upon the persons who are victims of medical malpractice.

SHOULD ALTERNATIVE DISPUTE RESOLUTION BE INCLUDED IN A NATIONAL HEALTH ACCESS PROPOSAL?

The ABA has long supported the use of various methods of alternative dispute resolution (ADR) and was an early leader in advocating for its use. We encourage providing appropriate ADR options in a national health access proposal as an efficient means of expediting medical malpractice claims.

In 1976, the ABA co-sponsored a conference in St. Paul, Minnesota. The conference sought to address two principal topics: "What types of disputes are best resolved by judicial action and what kinds are better assigned to another more appropriate forum?" and "Can the interest of justice be better served with processes less time-consuming and less expensive?" The conference discussions led to the appointment of a "Pound Conference Follow-up Task Force," under the chairmanship of Judge Griffin Bell. The Task Force published a report with numerous recommendations for justice reform in August, 1976.

A principal recommendation of the report is that a variety of innovative dispute resolution techniques be explored: arbitration, mediation, revitalized and expanded small claims courts, and the concept of a "neighborhood justice center."

In 1977, when the ABA established its Standing Committee on Dispute Resolution, that subject was relatively obscure; however, during the past 16 years, the ABA through its Standing Committee and its newly established Section on Dispute Resolution, has chartered the nation's dispute resolution agenda. The Multi-Door Courthouse, school mediation and police dispute resolution programs were unknown concepts until after the ABA's 1976 Conference on Improvements in the Administration of Justice.

Today, the dispute resolution world is dramatically different. Much has happened, in part because of ABA leadership. The extensive work of the ABA is described in a document entitled the ABA Blueprint for Improving the Civil Justice System. Copies of the "Blueprint" are available upon request.

The ABA's House of Delegates has adopted four resolutions relevant to ADR and medical malpractice. The resolutions call for the following:

1. To promote continued use of and experimentation with ADR, both before and after suit is filed, as welcome components of the justice system.
(Adopted August 1989.)

- 10 -

2. Consistent with the attached ABA policy (Appendix D), to support the increased use of ADR by federal agencies, which included support for the recently passed Administrative Dispute Resolution Act of 1990. (Adopted August 1988.)
3. To support the use of arbitration for resolution of medical malpractice disputes under circumstances whereby the agreement to arbitrate is entered into only after a dispute has arisen. (Adopted August 1977.)
4. To support the voluntary use of arbitration so long as the parties have full knowledge that once entered into, the arbitration panel's decision is final and binding; and that arbitration panels should consist of one impartial arbitrator in "small" claims cases and three arbitrators - an attorney, a physician, and a layman in larger claims cases. (Adopted August 1976.)

The ABA is concerned about achieving a more expeditious and economical resolution of medical malpractice litigation. Voluntary alternative dispute resolution, for example, has gained acceptance as an alternative to litigation. The ABA recognizes the importance of the development and use of ADR methods other than full judicial trials for resolving legal disputes. ABA policy supports the "continued use of and experimentation with alternative dispute resolution techniques both before and after suit is filed," so long as they assure that every disputant's constitutional and other legal rights and remedies are protected. Of course, such concepts have equal validity in litigation against any defendant, and no special justification exists for being applied only in cases involving medical professionals.

The use of voluntary alternative dispute resolution techniques is consistent with the relevant policy considerations of attracting to an overburdened judicial system the independent and impartial services and expertise upon which that system necessarily depends. Besides relieving court congestion and speeding up the conclusion of cases, these alternative dispute resolution procedures are often less expensive and less stressful than seeing a case through its normal trial path.

Thank you for giving us this opportunity to present our views to you.

ENDNOTES

- 1 Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992.
- 2 Congressional Budget Office, Economic Implications of Rising Health Care Costs (October 1992) page 27.
- 3 The American Medical Association has estimated the cost of defensive medicine based upon a survey of physicians who were asked, for example, whether they ordered more tests because of the perceived risk of a medical malpractice claim. The AMA, moreover, recognized other reasons contributed to an affirmative response, stating, "like other defensive measures, all defensive medicine cannot be characterized necessarily as overuse but can reflect necessary improvements in patient care." Statement on behalf of the American Medical Association to the Senate Finance Subcommittee on Medicare and Long Term Care Regarding Medical Liability Reform, October 16, 1991, page 4.
- 4 The Physician Payment Review Commission (PPRC) has questioned such figures, noting that "Studies that use physicians' estimates of the amount of defensive medicine they practice are not sufficiently reliable to make quantitative estimates." Physician Payment Review Commission 1991 Annual Report to Congress, page 374.
- 5 Mark N. Cooper, "Physician Self-Dealing for Diagnostic Tests in the 1980s: Defensive Medicine vs. Offensive Profits," Consumer Federation of America, October 3, 1991, reported that the rapid spread of physician ownership of diagnostic testing facilities is a much more likely cause of rising diagnostic costs than fear of malpractice liability.

A January 1991 study by the State of Florida's Health Care Cost Containment Board looked into physician ownership of health care facilities. It found that joint ventures among health care providers resulted in higher health care costs due primarily to the over-utilization of services.

A study of radiation centers in Florida found that doctor-owned centers appeared to result in a substantial increase in use and cost of the services. See Mitchell, Jean M.; Sunshine, Jonathan H.; "Consequences of Physicians' Ownership of Health Care Facilities - Joint Ventures in Radiation Therapy, The New England Journal of Medicine, Vol.327, No.21, Nov. 19, 1992, pages 1497-1501.

Another study examined workers' compensation claims in California and found that self-referral increases the cost of medical care covered by workers' compensation for physical therapy, psychiatric evaluation services and MRI Scans. Swedlow, Alex; Johnson, Gregory; Smithline, Neil; and Milstein, Arnold, "Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians," The New England Journal of Medicine, Vol.327, No.21 Nov. 19, 1992, pages 1502-1506.

- 6 Patricia M. Danzon, "Liability for Medical Malpractice," Journal of Economic Perspectives, Vol.5, No.3, Summer 1991, pages 51-69. Ms. Danzon concludes that liability concerns have brought about some efficient changes in practice.

The Physician Payment Review Commission Annual 1991 Report also discusses other possible causes of inefficient and inappropriate defensive medicine.

- * Physicians and hospitals often benefit financially by delivering more care.
- * Insurance does not deter physicians from ordering additional tests because insurance provides funding for that which a patient could not otherwise afford.
- * So-called defensive medicine practices often have become the standard of care adopted by the medical community, and reflect an advancement in technology or care.

- 7 Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992, Appendix F, page 32.

- 8 Andrea Dubin, False Claims: The Relationship between Medical Malpractice "Reforms" and Health Care Costs, prepared for the Coalition for Consumer Rights, March 1993, at Page 2.

- 9 Medical and Hospital Professional Liability," a report prepared for the Texas Health Policy Task Force by Tomm and Associates, July 1992.

- 10 1989 Profitability Study (By Line By State) 1990 Profitability Study (By Line By State), 1991, Profitability Study (By Line By State), 1992 Profitability Study, (By Line By State), National Association of Insurance Commissioners, 1990, 1991, 1992 and 1993.

- 11 Martin L. Gonzalez "Medical Professional Claims and Premiums 1985-1990," Socioeconomic Characteristics of Medical Practice 1992, page 23.

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES
February 11, 1986

Be It Resolved, That

(1) The American Bar Association urges appropriate ABA entities, such as the Action Commission to Improve the Tort Liability System and the Commission on Professionalism, to continue to consult, where appropriate, with representatives of the American Medical Association and others in the health care industry, the insurance industry, state and federal governments and appropriate segments of the public with the goal of seeking a broader consensus on how more equitably to compensate persons injured in our society. The problems associated with medical professional liability are common to all areas of tort law and should be evaluated in the context of their broader implications for the tort system as a whole. The legal and medical professions should cooperate in seeking common solutions to these problems and should avoid any efforts to polarize the discussion of these problems, which would serve neither the public interest nor the interests of either profession.

(2) Consistent with these goals, the American Bar Association adopts the following principles:

a. The regulation of medical professional liability is a matter for state consideration; and federal involvement in that area is inappropriate.

b. There should be rigorous enforcement of professional disciplinary code provisions which proscribe lawyers from filing frivolous suits and defenses; and sanctions should be imposed when those provisions are violated.

c. There should be more effective procedures and increased funding to strengthen medical licensing and disciplinary boards at the state level; and efforts should be increased to establish effective risk management programs in the delivery of health care services.

d. No justification exists for exempting medical malpractice actions from the rules of punitive damages applied in tort litigation to deter gross misconduct.

e. No disclosure of financial worth by a defendant in a tort action should be required unless there is a showing by evidence in the record or proffered by the plaintiff that would provide a legal basis for recovery of punitive damages.

f. Notices of intent to sue, screening panels and affidavits of non-involvement are unnecessary in medical malpractice actions.

g. No justification exists for a special rule governing malicious prosecution actions brought by health care providers against persons who sued them for malpractice.

h. Trial courts should scrutinize carefully the qualifications of persons presented as experts to assure that only those persons are permitted to testify who, by knowledge, skill, experience, training or education, qualify as experts.

i. The collateral source rule should be retained; and third parties who have furnished monetary benefits to plaintiffs should be permitted to seek reimbursement out of the recovery.

j. Contingent fees provide access to the courts; and no justification exists for imposing special restrictions on contingent fees in medical malpractice actions.

k. The use of structured settlements should be encouraged.

l. Collection and study of data on the cost and causes of professional liability claims should be undertaken to evaluate and develop effective loss prevention programs.

**RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES**

February 16-17, 1987
(Report No. 123)

Be It Resolved, That the American Bar Association adopts the following recommendations:

A. Insurance

1. The American Bar Association should establish a commission to study and recommend ways to improve the liability insurance system as it affects the tort system.

B. Pain and Suffering Damages

2. There should be no ceilings on pain and suffering damages, but instead trial and appellate courts should make greater use of the power of remittitur or additur with reference to verdicts which are either so excessive or inadequate as to be clearly disproportionate to community expectations by setting aside such verdicts unless the affected parties agree to the modification.

3. One or more tort award commissions should be established, which would be empowered to review tort awards during the preceding year, publish information on trends, and suggest guidelines for future trial court reference.

4. Options should be explored by appropriate ABA entities whether additional guidance can and should be given to the jury on the range of damages to be awarded for pain and suffering in a particular case.

C. Punitive Damages

5. Punitive damages have a place in appropriate cases and therefore should not be abolished. However, the scope of punitive damages should be narrowed through the following measures:

a. Standards of Conduct and Proof

Punitive damages should be limited to cases warranting special sanctions and should not be commonplace. A threshold requirement for the submission of a punitive damages case to the finder of fact should be that the defendant demonstrated a conscious or deliberate disregard with respect to the plaintiff. As a further safeguard, the standard of proof to be applied should be "clear and convincing" evidence as opposed to any lesser standard such as "by a preponderance of the evidence."

b. The Process of Decision

(1) Pre-Trial - Appropriate pre-trial procedures should be routinely utilized to eliminate frivolous claims for punitive damages prior to trial, with a savings mechanism available for late discovery of misconduct meeting the standard of liability.

(2) Trial - Evidence of net worth and other evidence relevant only to the question of punitive damages ordinarily should be introduced only after the defendant's liability for compensatory damages and the amount of those damages have been determined.

(3) Post-Trial - As a check against excessive punitive damage awards, verdicts including such awards should be subjected to close scrutiny by the courts. The trial court should order remittitur wherever justified. Excessiveness should be evaluated in light of the degree of reprehensibility of the defendant's acts, the risk undertaken by the plaintiff, the actual injury caused, the net worth of the defendant, whether the defendant has reformed its conduct and the degree of departure from typical ratios (as reflected in the best available empirical data) between compensatory and punitive damages. If necessary to assure such judicial review, appropriate legislation should be enacted. Opinions issued by trial or appellate courts either upholding or modifying an award should specify the factors which were considered and relied upon.

c. Multiple Judgment Torts

While the total amount of any punitive damages awarded should be adequate to accomplish the purposes of punitive damages, appropriate safeguards should be put in force to prevent any defendant from being subjected to punitive damages that are excessive in the aggregate for the same wrongful act.

d. Vicarious Liability

With respect to vicarious liability for punitive damages, the provisions of Section 909 of the Restatement (Second) of Torts (1979) should apply. Legislatures and courts should be sensitive to adopting appropriate safeguards to protect the master or principal from vicarious liability for the unauthorized acts of nonmanagerial servants or agents.

e. To Whom Awards Should Be Paid

In certain punitive damages cases, such as torts involving possible multiple judgments against the same defendant, a court could be authorized to determine what is a reasonable portion of the punitive damages award to compensate the plaintiff and counsel for bringing the action and prosecuting the punitive damage claim, with the balance of the

award to be allocated to public purposes, which could involve methods of dealing with multiple tort claims such as consolidation of claims or forms of class actions. The novelty of such proposals and the absence of any adequately tested programs for implementing require further study before an informed judgment can be made as to whether, or to what extent, such proposals will work in practice. We urge such studies. The concept of public allocation of portions of punitive damage awards in single judgment actions is also worthy of consideration to the extent workable methods of implementation may hereafter be developed.

D. Joint-and-Several Liability

6. The doctrine of joint-and-several liability should be modified to recognize that defendants whose responsibility is substantially disproportionate to liability for the entire loss suffered by the plaintiff are to be held liable for only their equitable share of the plaintiff's noneconomic loss, while remaining liable for the plaintiff's full economic loss. A defendant's responsibility should be regarded as "substantially disproportionate" when it is significantly less than any of the other defendants; for example, when one of two defendants is determined to be less than 25% responsible for the plaintiff's injury.

E. Attorneys' Fees

7. Fee arrangements with each party in tort cases should be set forth in a written agreement that clearly identifies the basis on which the fee is to be calculated. In addition, because many plaintiffs may not be familiar with the various ways that contingency fees may be calculated, there should be a requirement that the contingency fee information form be given to each plaintiff before a contingency fee agreement is signed. The content of the information form should be specified in each jurisdiction and should include at least the maximum fee percentage, if any, in the jurisdiction, the option of using different fee percentages depending on the amount of work the attorney has done in obtaining a recovery, and the option of using fee percentages that decrease as the size of a recovery increases. The form should be written in plain English, and, where appropriate, other languages.

8. Courts should discourage the practice of taking a percentage fee out of the gross amount of any judgment or settlement. Contingent fees should normally be based only on the net amount recovered after litigation disbursements such as filing fees, deposition costs, trial transcripts, travel, expert witness fees, and other expenses necessary to conduct the litigation.

9. Upon complaint of a person who has retained counsel, or who is required to pay counsel fees, the fee arrangement and the fee amount billed may be submitted to the court or other appropriate public body, which should have the authority to disallow, after a hearing, any portion of a fee found to be "plainly excessive" in light of prevailing rates and practices.

F. Secrecy and Coercive Agreements

10. Where information obtained under secrecy agreements (a) indicates risk of hazards to other persons, or (b) reveals evidence relevant to claims based on such hazards, courts should ordinarily permit disclosure of such information, after hearing, to other plaintiffs or to government agencies who agree to be bound by appropriate agreements or court orders to protect the confidentiality of trade secrets and sensitive proprietary information.

11. No protective order should contain any provision that requires an attorney for a plaintiff in a tort action to destroy information or records furnished pursuant to such order, including the attorney's notes and other work product, unless the attorney for a plaintiff refuses to agree to be bound by the order after the case has been concluded. An attorney for plaintiff should only be required to return copies of documents obtained from the defendant on condition that defendant agrees not to destroy any such documents so that they will be available, under appropriate circumstances, to government agencies or to other litigants in future cases.

12. Any provision in a settlement or other agreement that prohibits an attorney from representing any other claimant in a similar action against the defendant should be void and of no effect. An attorney should not be permitted to sign such an agreement or request another attorney to do so.

G. Streamlining the Litigation Process: Frivolous Claims and Unnecessary Delay

13. A "fast track" system should be adopted for the trial of tort cases. In recommending such a system, we endorse a policy of active judicial management of the pre-trial phases of tort litigation. We anticipate a system that sets up a rigorous pre-trial schedule with a series of deadlines intended to ensure that tort cases are ready to be placed on the trial calendar within a specified time after filing and tried promptly thereafter. The courts should enforce a firm policy against continuances.

14. Steps should be taken by the courts of the various states to adopt procedures for the control and limitation of the scope and duration of discovery in tort cases. The courts should consider, among other initiatives:

(a) At an early scheduling conference, limiting the number of interrogatories any party may serve, and establishing the number and time of depositions according to a firm schedule. Additional discovery could be allowed upon a showing of good cause.

(b) When appropriate, sanctioning attorneys and other persons for abuse of discovery procedures.

15. Standards should be adopted substantially similar to those set forth in Rule 11 of the Federal Rules of Civil Procedure as a means of discouraging dilatory motions practice and frivolous claims and defenses.

16. Trial judges should carefully examine, on a case-by-case basis, whether liability and damage issues can or should be tried separately.

17. Nonunanimous jury verdicts should be permitted in tort cases, such as verdicts by five of six or ten of twelve jurors.

18. Use of the various alternative dispute resolution mechanisms should be encouraged by federal and state legislatures, by federal and state courts, and by all parties who are likely to, or do become involved in tort disputes with others.

II. Injury Prevention/Reduction

19. Attention should be paid to the disciplining of all licensed professionals through the following measures:

(a) A commitment to impose discipline, where warranted, and funding of full-time staff for disciplinary authorities. Discipline of lawyers should continue to be the responsibility of the highest judicial authority in each state in order to safeguard the rights of all citizens.

(b) In every case in which a claim of negligence or other wrongful conduct is made against a licensed professional, relating to his or her profession, and a judgment for the plaintiff is entered or a settlement paid to an injured person, the insurance carrier, or in the absence of a carrier, the plaintiff's attorney, should report the fact and the amount of payment to the licensing authority. Any agreement to withhold such information and/or to close the files from the disciplinary authorities should be unenforceable as contrary to public policy.

I. Mass Tort

20. The American Bar Association should establish a commission as soon as feasible, including members with expertise in tort law, insurance, environmental policy, civil procedure, and regulatory design, to undertake a comprehensive study of the mass tort problem with the goal of offering a set of concrete proposals for dealing in a fair and efficient manner with these cases.

J. Concluding Recommendation

21. After publication of the report, the ABA Action Commission to Improve the Tort Liability System should be discharged of its assignment.

HEALTH CARE COSTS and TORT "REFORM"

Attached is a chart showing the percentage of increase from 1982 to 1990 in personal health care spending per capita by state. It is derived from a February 1992 report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences," published by the General Accounting Office (GAO). The GAO report utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF.

Health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted, as is demonstrated by the attached chart.

For example, based on the figures utilized in the GAO report, the three states with percentage increases estimated to be slightly lower than average -- Arkansas, Kentucky and Mississippi -- had no caps on damages in medical malpractice cases. Alabama, with a slightly higher than average estimated percentage increase, had a cap on damages. Massachusetts and California, the two states with the highest estimated personal health care costs per capita, had in place a cap on damages.

*The attached chart was developed by the American Bar Association Special Committee on Medical Liability and the ABA Governmental Affairs Office, May 1993.
Contact: Lillian B. Gaskin, Staff Liaison to the Special Committee (202/331-2604).*

**Percentage of Increase from 1982 to 1990 in Personal Health Care Costs
Per Capita, State by State**

<u>RANKING/STATE*</u>	<u>1982 HCFA data*</u>	<u>1990 LEWIN/ICF Estimates*</u>	<u>% of INCREASE**</u>
1 Massachusetts	\$1,508	\$3,031	101
2 California	1,451	2,894	99
3 New York	1,417	2,818	99
4 Nevada	1,380	2,757	100
5 Rhode Island	1,351	2,707	100
6 Connecticut	1,348	2,699	100
7 North Dakota	1,325	2,661	101
8 Illinois	1,308	2,619	100
9 Missouri	1,285	2,568	100
10 Michigan	1,281	2,569	101
11 Pennsylvania	1,273	2,536	99
12 Kansas	1,271	2,548	100
13 Ohio	1,247	2,493	100
14 Maryland	1,232	2,436	98
15 Minnesota	1,229	2,480	102
16 Hawaii	1,228	2,469	101
17 Florida	1,228	2,427	98

RANKING/STATE*	1982		1990	
	HCFA data*		LEWIN/ICF Estimates*	
				% of INCREASE**
18 Wisconsin	1,219	2,449	101	
19 Nebraska	1,216	2,452	102	
20 Colorado	1,209	2,415	100	
21 Alaska	1,187	2,367	99	
22 Iowa	1,176	2,351	100	
23 Washington	1,165	2,311	98	
24 Oregon	1,165	2,312	98	
25 South Dakota	1,154	2,322	101	
26 Delaware	1,153	2,268	97	
27 Tennessee	1,144	2,262	98	
28 New Jersey	1,115	2,224	99	
29 Arizona	1,112	2,211	99	
30 Texas	1,110	2,192	97	
31 Louisiana	1,106	2,185	98	
32 Indiana	1,101	2,201	100	
33 Maine	1,091	2,175	99	
34 Oklahoma	1,086	2,139	97	
35 West Virginia	1,057	2,088	98	

<u>RANKING/STATE*</u>	<u>1982</u> <u>HCFA data*</u>	<u>1990</u> <u>LEWIN/ICF Estimates*</u>	<u>% of INCREASE**</u>
36 Virginia	1,054	2,076	97
37 Georgia	1,048	2,072	98
38 Montana	1,036	2,059	99
39 Alabama	1,033	2,286	121
40 Arkansas	994	1,944	96
41 New Hampshire	986	1,981	101
42 Vermont	978	1,956	100
43 Kentucky	957	1,875	96
44 North Carolina	931	1,833	97
45 New Mexico	904	1,792	98
46 Mississippi	897	1,751	95
47 Utah	896	1,784	99
48 Wyoming	873	1,756	101
49 Idaho	868	1,726	99
50 South Carolina	857	1,689	97
U.S. Average	1,220	2,425	99

* This data was obtained from a February 1992 GAO report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences." Note that the Lewin/ICF estimates are not directly comparable with the HCFA data because the Lewin/ICF estimates also include administrative costs for private insurance which are excluded from HCFA's data on personal health care expenditures. GAO reported that it conducted its review "in accordance with generally accepted government auditing standards." HCFA estimates that 1990 U.S. personal health expenditures per capita averaged \$2,255.

** Rounded off to the nearest whole number.

RESOLUTION APPROVED BY THE
AMERICAN BAR ASSOCIATION
HOUSE OF DELEGATES
AUGUST 1988

APPENDIX D.

Be It Resolved, That the American Bar Association supports the increased use of alternative means of dispute resolution by Federal administrative agencies consistent with the following

A. General

1. Administrative agencies should adopt alternative methods of dispute resolution for resolving a broad range of issues. These techniques include arbitration, factfinding, mini-trials, and mediation. The issues for which they may be employed include matters that arise in formal or informal adjudication, in rulemaking, in issuing or revoking permits, and in settling disputes, including litigation brought by or against the government.
2. Congress and the courts should not inhibit agency uses of the ADR techniques by requiring formality where it is inappropriate.

B. Voluntary Arbitration

3. Congress should act to permit executive branch officials to agree to binding arbitration to resolve controversies. This legislation should authorize any executive official who has authority to settle a matter on behalf of the government to agree to arbitration, either prior to the time a dispute may arise or after a controversy has matured, subject to whatever may be the statutory authority of the Comptroller General to determine whether payment of public funds is warranted by applicable law and available appropriations.
4. Congress should authorize agencies to adopt arbitration procedures to resolve matters that would otherwise be decided by the agency pursuant to the Administrative Procedure Act ("APA") or other formal procedures. These procedures should provide that:
 - (a) All parties to the dispute must knowingly consent to use the arbitration procedures, either before or after a dispute has arisen.
 - (b) The parties have some role in the selection of arbitrators, whether by actual selection, by ranking those on a list of qualified arbitrators, or by striking individuals from such a list.

- (c) Arbitrators need not be permanent government employees, but may be individuals retained by the parties or the government for the purpose of arbitrating the matter.
 - (d) Agency review of the arbitral award be pursuant to the standards for vacating awards under the U.S. Arbitration Act, 9 U.S.C. §10, unless the award does not become an agency order or the agency does not have any right of review.
 - (e) The award includes a brief, informal discussion of its factual and legal basis, but neither formal findings of fact nor conclusions of law.
 - (f) Any judicial review is pursuant to the limited scope-of-review provisions of the U.S. Arbitration Act, rather than the broader standards of the APA.
 - (g) The arbitral award is enforced pursuant to the U.S. Arbitration Act but is without precedential effect for any purpose.
5. Factors bearing on agency use of arbitration are:
- (a) Arbitration is likely to be appropriate where —

- (1) The benefits that are likely to be gained from such a proceeding outweigh the probable delay or costs required by a full trial-type hearing.
- (2) The norms which will be used to resolve the issues raised have already been established by statute, precedent, or rule, or the parties explicitly desire the arbitrator to make a decision based on some general standard, such as "justice under the circumstances," without regard to a prevailing norm.
- (3) Having a decisionmaker with technical expertise would facilitate the resolution of the matter.
- (4) The parties desire privacy, and agency records subject to disclosure under the Freedom of Information Act are not involved.

(b) Arbitration is likely to be inappropriate where —

- (1) A definitive or authoritative resolution of the matter is required or desired for its precedential value.
- (2) Maintaining established norms or policies is of special importance.
- (3) The case significantly affects persons who are not parties to the proceeding.
- (4) A full public record of the proceeding is important.
- (5) The case involves significant decisions as to government policy.

C. Mandatory Arbitration

6. Arbitration is not in all instances an adequate substitute for a trial-type hearing pursuant to the APA or for civil litigation. Hence, Congress should consider mandatory arbitration only where the advantages of such a proceeding are clearly outweighed by the need to (a) save the time or transaction costs involved or (b) have a technical expert resolve the issues.
7. Mandatory arbitration is likely to be appropriate only where the matters to be resolved —
 - (a) Are not intended to have precedential effect other than the resolution of the specific dispute, except that the awards may be published or indexed as informal guidance;
 - (b) May be resolved through reference to an ascertainable norm such as statute, rule or custom;
 - (c) Involve disputes between private parties; and
 - (d) Do not involve the establishment or implementation of major new policies or precedents.
8. Where Congress mandates arbitration as the exclusive means to resolve a dispute, it should provide the same procedures as in Paragraph 4, (b) - (g) above, except that judicial review should be pursuant to the Administrative Procedure Act, but with the courts' bearing in mind the purposes to be gained by arbitration.

Mr. BROOKS. Mr. Keener.

STATEMENT OF ROBERT C. BAKER, PRESIDENT, AMERICAN BOARD OF TRIAL ADVOCATES, PRESENTED BY KARL A. KEENER, BAKER, SILBERBERG & KEENER

Mr. KEENER. Thank you, Mr. Chairman, members of the committee.

Mr. BROOKS. I know lawyers can't stay within 5 minutes, but let's make a better effort.

Mr. CORBOY. I was waiting for a red light. I apologize.

Mr. BROOKS. Go ahead, Mr. Keener.

Mr. KEENER. Five minutes, Mr. Chairman. My law partner, Robert Baker, national president of ABOTA, the American Board of Trial Advocates, has submitted to this subcommittee his written testimony.

At the time that Mr. Baker requested the opportunity to testify before this subcommittee, the hearing date had not as yet been set. Unfortunately, he had a longstanding business commitment outside of the country that could not be canceled.

He therefore asked me as a member of ABOTA and as his law partner to appear in his stead. ABOTA is a national association of more than 4,000 prominent trial lawyers and legal scholars throughout the United States. Our membership is almost evenly divided between lawyers representing plaintiffs and defendants.

In order to be considered for ABOTA membership, one must have tried at least 20 civil jury trials, to verdict and be approved for membership by the local chapter and the national board. My partner, Robert Baker, brought to the presidency of ABOTA over 20 years of practice specializing in the defense of physicians in southern California.

It is from this perspective that Mr. Baker has presented his opinions concerning the California experiment with its provisions—most of which or many of which now appear in proposed Federal legislation. I should note that in my firm, which consists of 35 lawyers, the vast majority of our practice is devoted to defending physicians.

In our view, while California's malpractice reforms may have aided insurance companies and to a lesser extent some physicians, it has been harmful for the victims of medical negligence. As a result of caps placed on noneconomic damages, and limitations on attorneys' fees, most exceptionally competent plaintiffs' attorneys in California simply will no longer handle medical malpractice cases.

Medical malpractice cases can take years to resolve and literally thousands of an attorney's hours and dollars. They are notoriously risky for a plaintiff's attorney to handle, because approximately 80 percent of all medical malpractice cases that go to trial are won by the defendants.

They are exceedingly expensive to prepare and try. A physician's consent to any settlement is required under their insurance policy, and thus the physician controls whether or not a case is settled or tried. And physicians frequently refuse to consent to settlements because of their fear of the reporting requirements of the medical board of California and the National Practitioner Data Bank.

As a result, those attorneys who choose to handle malpractice cases concentrate only on those cases that have high economic damages associated with them, such as the brain damaged baby, or the wrongful death of a significant wage earner.

The end result is that patients who suffer noncatastrophic injuries are effectively left without representation. This is particularly true of homemakers, low-wage earners, and senior citizens.

If by settling, a physician is going to be reported to the National Practitioner Data Bank and/or the medical board, he or she has very little to lose by proceeding to trial where there is an 80 percent chance of winning.

In H.R. 3600 there is the reporting requirement that allows the public to obtain access to information contained in the National Practitioner Data Bank. In addition, there are provisions for ADR process through which consumers are required to first attempt to resolve the claim.

Similar to the situation in California under MICRA, these two provisions work at cross-purposes. First, mandatory ADR is very expensive for both sides, and either side can opt to go forward with the litigation. If the patient wins, the physician has little to lose by seeking the jury trial to which he or she is entitled.

If the Congress is intent on enacting malpractice reforms, and we hope you are not, which include mandatory reporting to the National Practitioner Data Bank, then we submit that this committee should consider incorporating a provision requiring that only settlements or verdicts in excess of \$50,000 need be reported.

This would result in far more physicians consenting to settlements of the more minor cases and thereby removing a large number of lawsuits from an already overextended judicial system.

With health care costs in the United States running in excess of \$800 million annually and malpractice insurance premiums representing less than 1 percent of that, alleged malpractice reform is not the answer to reducing health care costs in the United States.

It is our view, based upon a significant amount of experience in California with the MICRA experiment, that the proposed medical malpractice reforms now under consideration by Congress will, in fact, result in more medical malpractice cases going to trial at substantially increased cost. It will also result in more victims of medical negligence being denied access to our justice system.

If time permits later, I would be happy to give you a number of examples of why I believe these opinions have been proven through 15 years of experience in California.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Baker follows:]

TESTIMONY OF
ROBERT C. BAKER
PRESIDENT, AMERICAN BOARD OF TRIAL ADVOCATES

PRESENTED BY
KARL KEENER
MEMBER, AMERICAN BOARD OF TRIAL ADVOCATES

BEFORE THE
SUBCOMMITTEE ON ECONOMIC AND COMMERCIAL LAW
COMMITTEE ON THE JUDICIARY
U.S. HOUSE OF REPRESENTATIVE
JUNE 22, 1994

I am Robert C. Baker, National President of the American Board of Trial Advocates. I am a Senior Partner in the firm of Baker, Silberberg & Keener, located in Santa Monica, California.

The American Board of Trial Advocates (ABOTA) is an organization of over 4000 distinguished litigators from all 50 states. We are unique in that our membership is almost evenly divided between lawyers representing plaintiffs and lawyers representing defendants. The composition of ABOTA's membership insures that its position on such issues as medical malpractice reform is balanced. ABOTA members have a distinctive understanding of the civil justice system, since a lawyer must have tried 20 civil jury trials to verdict, in order to be even considered for membership in our organization.

The majority of my personal practice for the last twenty plus years has been devoted to defending physicians at the request of their medical malpractice insurance carrier. Indeed, my firm generates most of its income through the defense of physicians at the request of medical malpractice insurers.

Today, I would like to give you my opinion, as a lawyer who represents the health industry not the plaintiff, on how medical malpractice reform has affected malpractice litigation in California. This should be important to this Committee's consideration since many proponents of malpractice reform cite the California law as successful reform and have incorporated many of its provisions in proposed federal legislation.

As you may recall the "MICRA" limitations were passed by the California Legislature in 1975 and were held constitutional by the California Supreme Court in almost all particulars in 1984 and 1985. We have had, therefore, approximately 10 years of experience with alleged malpractice reforms.

In my view, those malpractice reforms have aided insurance companies and physicians, but have, to a significant extent, been detrimental to persons injured by medical negligence. As a result of caps on damages, as well as limitations on attorneys' fees, most of the exceedingly competent plaintiff's lawyers in California simply will not handle a medical malpractice case. This is a fact, and let me explain why.

First, the contingent fee allows access to the courts for those who lack the means to pay a lawyer's hourly fees. It provides a client the means to finance litigation with funds essentially borrowed from the lawyer. If the lawyer loses the case it is as if he or she made a bad loan.

Lawyers cannot earn a living by making bad loans, so they will only make those loans when there is a good opportunity for a return. The sliding scale limitation on the contingent fee further reduces those opportunities, since it has the effect of underestimating the amount of time needed for particular cases.

Medical malpractice cases can take years to resolve and thousands of hours of attorney time. They are notoriously risky. I would also suggest that even if some attorneys would still take these cases, the quality of counsel would not be the same.

Moreover, when the contingent fee limitation is restricted to one area of tort law, such as medical malpractice, tort lawyers simply shift into more profitable areas of practice. This only worsens the problem of the inability of medical malpractice victims to obtain representation.

The result is that those attorneys that choose to handle medical malpractice cases concentrate on only those cases that have high economic damages associated with them, such as cases commonly referred to as "bad baby cases," wrongful death cases of a breadwinner, or cases involving demonstrable brain damage. Those cases also attract the attention of the media and the public and lead to the misunderstanding that surrounds medical malpractice litigation.

There are entire categories of cases that have been eliminated since malpractice reform was implemented in California. The victims of cases that have a value between \$50,000 and \$150,000 are basically without representation. As an example, incidents of failure to diagnose an appendicitis still occur, but suits are not filed to any extent in California. The reasons for this are simple:

- (1) 80% of medical malpractice cases that go to trial are won by the defendant medical practitioner;
- (2) Medical malpractice cases by their very nature are expensive.
- (3) Physicians in California, as in virtually all states have the ability to withhold consent to settle and, therefore, the physicians control whether a case is settled or goes to trial;
- (4) Physicians in California are required to report malpractice settlements to the Medical Board of California.

If, by settling, a physician is to be reported to the Medical Board, he or she has very little to lose by proceeding to a trial where the chances of success are 80%. They are in no worse position professionally if they lose than they would be by being reported to the Medical Board. Under those conditions, given the expense to the plaintiff and the plaintiff's attorney, cases in the \$50,000-\$150,000 range are rarely filed.

On the other hand, of the medical malpractice cases filed, a far greater number will proceed to trial, as opposed to being settled. In California a significantly higher percentage of medical malpractice cases go to trial--the costly alternative--than any other type of case.

Medical malpractice premiums have not diminished in California as a result of MICRA, nor to my knowledge have they in any state that has enacted alleged medical malpractice reform. There can be little doubt that with caps on pain and suffering and limitations on attorneys' fees there are fewer cases being filed (although, as stated, of those filed more go to trial). I believe these realities confirm the studies conducted elsewhere, which assert that damages recovered from litigation are not unwarranted nor are they a prime cause for high malpractice premiums.

A Harvard study¹ in 1990 found that of more than 27,000 victims of doctor negligence, fewer than one in eight filed suit, and less than 40% of those victims, or 5% of the total, recovered compensation. A more comprehensive study² by Professor Neal Vidmar at Duke University School of Law broadly examined malpractice litigation in North Carolina and found of the nearly 900 cases that were filed in a three-year period in North Carolina, 40% were terminated without payment to plaintiff, 50% resulted in a settlement, and 10% were eventually decided by a jury.

The plaintiffs in jury cases prevailed in one out of five times, which is approximately the national average. There were only four large awards out of the 117 cases that went to trial and the median award of those 117 lawsuits was \$36,500.00

¹Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, a report by the Harvard Medical Practice Study to the State of New York (1990).

²Neil Vidmar, "The Unfair Criticism of Medical Malpractice Juries," Judicature, October-November 1992, Vol. 76, No. 3.

In H.R. 3600 there are provisions for an alternative dispute resolution process through which consumers are required to first attempt to resolve the claim. In addition, there is the reporting requirement that allows the public to obtain access to information contained in the National Practitioner Data Bank.

Similar to the situation in California in which the physician has little incentive to settle, these two provisions work at cross-purposes. First, mandatory ADR is very expensive and will cost the plaintiffs and the plaintiff's attorneys, as well as the defendants and their insurers, considerable monies with which to comply. However, the chances of success of ADR are exceedingly diminished by the reporting requirements to the National Practitioner Data Bank.

In other words, if a physician wins the ADR, and the patient opts to go no further, then obviously the dispute between the patient and the physician would end. In the alternative, if the patient wins the ADR, the physician has little to lose by seeking the jury trial to which he or she is entitled. Unless some sort of reporting floor is established, the alternative dispute resolution process, in my opinion, will not eliminate a significant number of disputes.

If the Congress is intent on enacting malpractice reforms which include the mandatory reporting to a National Practitioner Data Bank, then this committee should consider incorporating a provision requiring only those health care providers that settle, or incur verdicts and/or judgements in excess of \$50,000 to report the matters to the National Practitioner Data Bank. This, in my view, would result in far more physicians consenting to settlements of the more minor cases, thereby removing a large number of lawsuits from our already clogged judicial system.

It is my opinion that malpractice reform has not worked in California for the injured victims of medical negligence. Physician groups report that there has been no reduction in their medical malpractice premiums. As the number of case filings has diminished and dollar amounts of awards have decreased, one can assume medical malpractice reform is benefitting some entity, but it most certainly is not benefitting the average citizen in our country.

With health care costs in the United States running at \$800 billion annually, and medical malpractice insurance running around \$6 billion--less than 1%, alleged medical malpractice reform is not the answer to reducing health care costs in the United States. In my view, this committee could do more to assist the American public by looking at some of the real costs that are incurred in the delivery of health care in our country.

One would not have to look beyond the most frequently performed surgery in the United States--the implantation of intraocular lens. The fifteen-minute operation may be performed by a physician anywhere from 6 to 20 times a day for which the charge may be \$2,500 or higher per operation. That same procedure in an outpatient hospital setting will cost in excess of \$7,500. The intraocular lens that is implanted by the physician may have approximately three to four cents of plastic in it and cost the hospital \$100-\$200. As of the early 1990's, the United States government was paying more for the implantation of intraocular lenses than for the next four most frequently performed operations combined.

Another example of real costs is the proliferation of expensive CAT and MRI machines. In the City of Santa Monica where I practice there are 7 MRI machines which are more than in the entire country of Canada. Because of their proliferation these wonderful but expensive machines are under-utilized. As a result, the cost of the diagnostic tests have gone up in order to cover the cost of the machine.

To conclude, it is my view, based on a significant amount of experience in the California experiment, that a reduction in health care costs is not going to be achieved by some of the far-reaching medical malpractice reform proposals now being considered by the Congress. What will occur is that victims of medical negligence will have a decreased opportunity for redress.

Thank you.

Mr. BROOKS. Ms. Wittkin.

**STATEMENT OF LAURA WITTKIN, EXECUTIVE DIRECTOR,
NATIONAL CENTER FOR PATIENTS' RIGHTS**

Ms. WITTKIN. Thank you. I am Laura Wittkin. I am the executive director of the National Center for Patients' Rights, which is a medical malpractice victim and patients' rights advocacy and support group. I am also a survivor of malpractice.

Thank you for inviting me to testify about the impact of medical malpractice on our health care system. Before I begin, I would just like to say that I am recovering from some dental surgery, so I am speaking a little more slowly than I normally would, so please bear with me.

I would like to address malpractice from three perspectives today: the emotional toll, the disparity between malpractice myth and reality, and finally, the administration's response to this silent public health epidemic.

Medical negligence is the Nation's third leading cause of preventable death. One hospital patient dies every 6 minutes in this country from malpractice, and that translates to 100,000 deaths and 300,000 serious injuries each year as a result of malpractice. And that is based on the Harvard Medical practice study.

It is simply incomprehensible to me how a problem of this magnitude has been ignored by each and every administration while the plight of real malpractice victims has been ridiculed and mocked. As a victim of malpractice, I have been left with lifelong disability and a constantly painful reminder of what happens when the public is left unprotected from incompetent and dangerous doctors.

My case was in California and was tried under MICRA, which is the Medical Injury Compensation Reform Act, so I am personally very familiar with how cruel and dehumanizing and regressive that tort reform is.

It is reform which does nothing but punish victims and reward wrongdoers. Yet, it is the same anticonsumer act that provides the framework for this administration's malpractice reforms.

As a patient advocate, most of my time is spent dealing with the flood of calls and letters we get from families and victims all over the country who are desperate for help, for answers and above all, for accountability.

And to ask you all to imagine what it is like to walk in our shoes, it is too cruel a request, I think, but somehow we must begin to recognize that malpractice victims are more than abstract statistics. They are your neighbors, they are your friends, they are your families, they are your constituents, the people that you are here to represent and protect.

Much of the malpractice to date has been eclipsed by outrageous myths perpetuated by the medical establishment, but let me give you some facts to dispel those myths and set the record straight. We don't have too many lawsuits in this country. We have too few.

More than 90 percent of victims never bring lawsuits. Negligent doctors already get a free ride on the shoulders of taxpayers who are forced to pay \$60 billion a year to provide care and services for victims that are already currently locked out of the tort system.

States that have adopted the reforms that are being discussed here today have all failed to realize any of these so-called benefits that the administration keeps talking about, whether it is increased access to care or reduction in health care spending for a State, and according to an upcoming Office of Technology Assessment study, the current liability system is not responsible for runaway defensive medicine practices in this country.

The OTA found that both the AMA and Lewin studies, which are being used by everybody in evaluating the defensive medicine issue, are unreliable, inaccurate, and based on empirically unsound evidence. They found that physicians rarely perform tests that will not benefit a patient and that much of what is mistakenly called defensive medicine is in fact sound medical practice.

OTA further concluded that while tort reform may lower premiums and physician's anxieties, it will not have any effect on defensive medicine spending in this country.

And finally, successful frivolous defenses by doctors who are guilty of malpractice far outnumber possible frivolous lawsuits by plaintiffs by a staggering 12 to 1 ratio. Sixty percent of indefensible cases are won by defendant doctors at trial, and that is outrageous.

For some reason though, these and many other facts which are in my written testimony and which have been shared with the White House on countless occasions have been ignored by this administration. Instead, their proposals punish both medical consumers and victims alike and do nothing to safeguard the delivery of quality health care.

For example, the elimination of the collateral source rule reduces the value of the case, makes it more difficult for victims to bring suit, and it also creates a hidden tax on both employers and health care consumers who are forced to pick up the entire bill for all of the collateral sources, collateral source benefits that these victims are entitled to.

Periodic payment of an award reduces the value of a case and it lets the wrongdoer get off cheap by purchasing an annuity for a fraction of the award amount. And the idea of imposing caps on noneconomic damages in addition to these other horrendous proposals is absolutely unthinkable.

All victims who are seriously injured would be devastated by such a cap, and in addition to that, our poor and our elderly, who are already far more dependent on the contingency fee system because they don't have significant compensable medical expenses or economic losses, will be virtually locked out if you impose any kind of a cap.

Nobody is going to argue about the need for health care reform in this country. But these reforms do nothing but create a more dangerous and costly health care environment. We need a system that is built around not only cost and access, but quality and medical malpractice prevention, and our organization has provided a number of recommendations. I would be happy to discuss them after everyone has testified, if you like.

Mr. BROOKS. Thank you very much.

[The prepared statement of Ms. Wittkin follows:]

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**TESTIMONY OF LAURA WITTKIN, EXECUTIVE DIRECTOR
ON MEDICAL MALPRACTICE AND HEALTH CARE REFORM**

**Before the
COMMITTEE ON THE JUDICIARY
SUBCOMMITTEE ON ECONOMIC AND COMMERCIAL LAW
JUNE 22, 1994**

Good morning, my name is Laura Wittkin. I am the Executive Director of the National Center for Patients' Rights, a medical malpractice victims' and patients' rights advocacy and support group. I am also a survivor of medical malpractice. Thank you for inviting me to testify about the very real impact medical malpractice has on our health care system. It is an issue of paramount importance to the safety and well-being of all Americans, yet one which has been all but forgotten in the overall health care debate.

Medical malpractice is one of the leading public health epidemics our nation faces today. It is the third leading cause of preventable death, second only to those deaths associated with cigarette smoking and alcohol abuse. And while this may not be a statistic the AMA will admit to, medical malpractice is a devastating problem to all Americans and it needs our immediate attention.

Center for Patients' Rights is a non-profit organization
dedicated to protecting the rights of medical consumers and victims of malpractice.

It is alarming that a problem of this magnitude can be ignored by this and every other administration to date. Instead of attacking the problem head-on, they have all chosen, instead, to turn a blind eye to this epidemic and the plight of its millions of victims.

Thanks to a highly effective medical industry campaign which maliciously and falsely stereotypes malpractice victims as greedy, conniving parasites feeding off of the system by persecuting "powerless" doctors for financial gain, the rights of victims and of all medical consumers in this country have been dealt a crushing blow.

We must move beyond the rhetoric of rich and powerful interest groups and rely on the wealth of empirical studies that show an out-of-control medical system which promotes inferior and substandard care. That system is responsible for the deaths and injuries of nearly a half million people a year. And we must also address the catastrophic fiscal impact that such substandard care has on our nation's health care system as a whole.

I would like to examine the malpractice issue from three different perspectives. The first, is the emotional impact of this epidemic. The second, is the disparity between the myths and realities of the medical malpractice system. And the third, is the Administration's response to the growing epidemic of medical malpractice.

I. EMOTIONAL IMPACT OF MEDICAL MALPRACTICE:

As a victim of medical malpractice, I am left with a lifelong handicap and the constantly painful reminder of what happens when the public is left unprotected against incompetent and dangerous doctors.

My malpractice case was tried in California eight years ago under the Medical Injury Compensation Reform Act, otherwise known as MICRA. Under MICRA I experienced, firsthand, the cruel and dehumanizing effects of regressive tort reform which rewards the wrongdoer and punishes their victims by callously limiting their legal redress and compensation. Unfortunately, it is this anti-consumer Act which provides the framework for the Clinton Administration's liability reform proposals.

My own life-threatening experience with medical malpractice led me to form the National Center for Patients' Rights (CPR), the largest advocacy and support group of its kind, where most of my day is spent responding to the overwhelming flood of calls and letters we receive from medical malpractice victims and their loved ones who are desperately crying out for help, answers, understanding, compassion and, above all, accountability.

The families that reach out to our organization are trying valiantly, though often unsuccessfully, to cope with the senseless loss of a child, the untimely death of a spouse or parent, permanent crippling injuries or unbearable pain and suffering which rob victims of their dignity and quality of life, and often leave entire households shattered in their wake.

In the last month, every network news show has aired a story on a different aspect of medical negligence and unfortunately, they haven't even scratched the surface of this enormous problem.

Someone suggested that I give you specific examples of the types of stories I hear, but I just don't know where to begin. Do I talk about the overwhelming problem of managed care and the alarming odds a patient in that type of setting takes on just being misdiagnosed.

Or do I tell you about the many mothers who call me because their children were killed by doctors who just wouldn't listen to the very real symptoms the child was complaining of.

Or, perhaps, I should recount the stories of the myriad of medical practitioners, be they doctors, nurses or lab technicians, who, one would think would be prepared for any and all emergencies, yet are, themselves pawns, just as all Americans are, when they become patients in our medical system.

All of the stories I hear are horrifying and heartbreaking and most typify the plight and human toll medical malpractice takes on us all. To even ask you to imagine yourselves in their shoes would be too cruel a request. But somehow you must be convinced that 100,000 deaths and more than 300,000 serious disabling injuries aren't just numbers... they are your neighbors, your friends, your families... they are your constituents, the people you are here to represent and protect.

You must understand that in the face of such true and sometimes interminable suffering, we have become sick and tired of hearing about how much doctors are the ones suffering from the threat of malpractice litigation. And we are tired of hearing how sleepless their nights are. No doctor's liability anxiety can ever begin to compare to the real life pain, loss or death suffered by hundreds of thousands of medical malpractice victims and their families in this country each and every day.

II. MEDICAL MALPRACTICE MYTH VERSUS REALITY:

The MYTHS about the malpractice system, which have been carefully propagated by the medical industry and now embraced by the Clinton Administration, are simply outrageous and groundless:

- MYTH:** The medical malpractice liability system is overwhelmed by excessive and frivolous lawsuits.
- MYTH:** Lawsuits result in outrageous jury awards, excessive plaintiff attorney fees, and do nothing to deter poor care.
- MYTH:** The liability crisis and high premiums are responsible for decreased access to care, runaway health care spending, and defensive medicine practices.

Permit me to set the record straight with the following facts (most of which belie the medical lobbies "self-anointed" status as "victims" of the medical malpractice system):

FACT: The current medical malpractice system actually prevents the majority of victims (90%) from bringing lawsuits, and most victims who receive awards are undercompensated based on the severity of their injuries.

FACT: The liability system as it exists today, already gives negligent practitioners and providers a free ride on the backs of the American taxpayers. It's the taxpayers who foot the sixty billion dollar bill each year to provide care and services to the hundreds of thousands of victims who have been locked out of the legal system. According to Dr. Troyen Brennan, co-author of the landmark Harvard Medical Practice Study, "this figure of \$60 billion is larger than the combined estimates of the costs of medical malpractice premiums (\$10 billion) and defensive medicine (\$10-\$20 billion)".

FACT: States which have adopted tort reforms similar to ones outlined in the Clinton Bill, have failed to realize any of the so-called benefits this Administration claims they have, such as: savings to the health care system, increased access to health care, more affordable care, or a reduction in "so-called" defensive medicine spending and "frivolous" lawsuits by plaintiffs. The Administration, nonetheless, insists on pushing the American people down this misguided path.

FACT: The malpractice liability system is not responsible for runaway "defensive medicine" practices. A soon to be released Study on Defensive Medicine and Medical Malpractice, by the Office of Technology Assessment (OTA) found that both the AMA and Lewin Studies on defensive medicine spending are inaccurate, unreliable and not based on empirically solid evidence. (Yet, these defensive medicine studies are still used as one of the primary justifications for national liability reform.)

OTA also found that physicians rarely perform tests that will not benefit patients, and that much of what is mistakenly characterized as "defensive medicine" practices is, in fact, sound medical practice. OTA concluded that while tort reform may lower premiums and a physician's anxiety, it will not effect the practice of defensive medicine.

These findings were echoed in an earlier Congressional Budget Office Report on Health Care Reform, which stated that even if medical malpractice liability were reformed, "much of the care that is commonly dubbed "defensive medicine" would probably continue to be provided for reasons other than concerns about malpractice."

FACT: The tort system DOES deter poor practices. According to Dr. Troy Brennan of the Harvard Study team, recent empirical analysis done at the hospital level found that as liability claims increased per 1,000 discharges, the risk of negligent injury for patients decreased. To quote Dr. Brennan, "this is the first statistically significant evidence that there is a deterrent effect associated with malpractice litigation. It suggests that tort litigation, with all of its warts, nonetheless accomplishes the task for which it is primarily intended, that is the prevention of medical injury".

FACT: Successful frivolous defenses by doctors, lawyers and insurance companies FAR OUTNUMBER "possible" frivolous plaintiff's verdicts by a staggering ratio of 12 to 1 according to a landmark study by the American College of Physicians, published in the Annals of Internal Medicine, November 1992. The study found that doctors currently win approximately 60% of indefensible cases at trial, compared to as few as 5% plaintiff wins in so-called defensible cases.

FACT: Victims of malpractice are forced to wait years for redress and compensation while insurance companies and defense attorneys, driven by their own financial self-interests, syphon off their profits through investment earnings and uncapped and outrageously high hourly defense fees for handling such cases -- All of which are responsible for driving up the cost of the medical liability system.

FACT: The malpractice system is not at all biased against doctors, but is, in fact, remarkably lenient towards them. It is a system in which doctors do not lose malpractice cases they should win. And it is a system whose payouts to victims are not based on the whims of overly sympathetic jurors, but rather are consistent with the extent of negligence and injury to the patient. (These findings are based on the 1992 American College of Physicians Study on medical malpractice lawsuits of New Jersey).

III. THE CLINTON ADMINISTRATION'S RESPONSE TO THE MEDICAL MALPRACTICE EPIDEMIC:

Despite the overwhelming evidence about the realities of the tort system, the Clinton Administration has, nonetheless, chosen to predicate its medical malpractice reform proposals on false premises.

When Ira Magaziner spoke about Health Care Reform at Citizen Action's National Conference in July of last year, he said the Administration would be basing medical malpractice reform on three KEY principles. They wanted to design a malpractice system which would:

1. **Increase access to the tort system for people who are currently locked out.**

2. Develop a national enforcement system for repeat malpractice offenders.

Ironically, Mr. Magaziner even went so far as to state that the Administration believed that doctors who commit malpractice twice should permanently lose their right to practice medicine in this country.

3. And last but not least, to ensure that victims receive the awards that they deserve both in non-economic and economic damages, while limiting all attorneys fees (defense fees, as well, as plaintiff fees).

But the Administration delivered just the opposite of what Mr. Magaziner promised. Almost all of the liability reform proposals in the Clinton Plan harm, punish and discriminate against medical consumers and victims of malpractice, and do absolutely nothing to safeguard the delivery of quality health care in this country.

Nowhere is the power of the medical and insurance lobbies more evident than in the text of this Bill. Although President Clinton begins by admitting that the cost of medical malpractice accounts for less than 2% of our nation's health care bill. Somehow, from this "less than two percent threat" comes legislation which virtually annihilates patients' recourse in the tort system, reduces their financial resources to deal with the harmful effects of medical malpractice... and allows negligent doctors to sleep better at night.

FOUR of these proposals are particularly troubling:

1. Elimination of Collateral Source Rule:

This reform requires that all victims' awards be automatically reduced by any past or future health care, social service, employment or other benefits they may be eligible for. However, there is no way to guarantee that all of a victim's medical needs will be met in a specific health care plan, or that they will, automatically in the future qualify for and receive other collateral benefits. Also, the reducing of awards by collateral sources, instead of allowing for subrogation, devalues a case, making it less economically viable for attorneys to take.

The net result of this proposal is the further victimization of patients harmed by substandard care and a **hidden health care tax** on employers and all taxpayers. because they are the ones who would be forced to pick-up the bill for all collateral source benefits.

2. Periodic Payment of Awards:

This reform states that, instead of paying out the entire award upfront, either party may request that the award be paid out over a period of many years or a lifetime. This proposal is yet another example of the cruel re-victimization of patients harmed by poor care, because **only DEFENDANTS** (and their insurance carriers) would ever make this request.

It allows the wrongdoer to purchase an annuity for a fraction of cost of the award (about 1/3 the cost), invest much of that money, and dole it out to the victim bit-by-bit over the course of the victim's lifetime.

This effectively shackles malpractice victims and their families to an endless bureaucratic system and deprives them of their award. And, if the victim dies BEFORE all of the award is paid out, the unpaid medical and economic losses go back into insurance company coffers, NOT to the victim's family.

Periodic payments also reduce the overall value of cases, again, creating a financial disincentive for attorneys to take those cases on.

3. **Alternative Dispute Resolution Mechanisms (ADR):**

This reform would require that all malpractice claimants first submit to some form of non-binding arbitration, mediation or early settlement process PRIOR to proceeding with a malpractice action. Because there is NO incentive to resolve the case, this proposal would simply drag out malpractice cases, cause further harm to the victims, and increase the cost of litigation. The only effective ADR mechanism which would, in fact, expedite cases and reduce the cost of litigation (but which is, unfortunately, NOT part of the Clinton Plan), would be binding arbitration for low-end cases, at the discretion of the plaintiff ONLY.

4. Practice Guidelines as a Defense:

This reform would establish a pilot program to test the use of practice guidelines as a DEFENSE in medical malpractice cases. This proposal is one-sided and grossly unfair, because evidence about compliance with guidelines could only be introduced at the discretion of the DEFENDANT.

The defendant would be able to literally pick and choose those cases in which they wish to introduce evidence of compliance with practice guidelines, while the plaintiff would be prohibited from introducing evidence about the FAILURE to follow those **same** guidelines as grounds for medical malpractice.

This discriminatory proposal is particularly harmful to medical malpractice victims since, according to the Physician Payment Review Commission, practice guidelines are already being successfully used in malpractice cases, far more by PLAINTIFFS, than by Defendants. Under the Clinton Bill, this would no longer be the case.

CONCLUSION:

This administration suffers from a skewed expression of outrage and misguided empathy over the emotional distress and inconvenience doctors feel when they are sued.

A sentiment which is, frankly, incomprehensible in the face of our nation's growing medical malpractice epidemic. Their complete failure to acknowledge **and** resolve the endless, suffocating pain and devastation negligent doctors inflict on victims and their families, is unconscionable.

For us, the litmus test of whether the Clinton Administration is truly designing a health care system that is in the best interest of the American people, a system based on careful, thoughtful and honest research and analysis of the entire health delivery system, can be seen in the way they have handled the issue of medical malpractice.

We had hoped for strong leadership and progressive malpractice reform solutions which would protect the rights of innocent people harmed by medical negligence while improving the overall quality of care. Instead, what this administration has given us is simply a repackaging of the same morally bankrupt and fiscally irresponsible tort reform garbage the medical industry has been peddling for years.

No one will argue about the urgent need to reform health care in this country. But, it must be a system based on sound public policy, not political expediency. In the final analysis it comes down to one simple question...Are we willing to pay for our medical care with our lives?

(A LIST OF RECOMMENDATIONS IS ATTACHED)



Center for Patients' Rights

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RECOMMENDATIONS

JUNE 22, 1994

**FEDERAL PRO-CONSUMER MEDICAL MALPRACTICE LIABILITY
REFORM RECOMMENDATIONS:**

To improve the malpractice liability system and protect the rights of medical consumers and victims of malpractice, the National Center for Patients' Rights recommends the following:

(NOTE: Where applicable, these reforms are intended to pre-empt state law.)

1. A three-year statute of limitations for the DISPOSITION of all malpractice cases (from date of filing).
2. Expedited handling of cases involving children and terminally ill patients.
3. Creation of a Small Claims Binding Arbitration Unit for cases under \$100,000.
4. A cap on defense attorney fees.
5. Removal of limitations or caps on non-economic damage awards.
6. Full, lump sum payment of awards, unless otherwise requested by the plaintiff.
7. Reinstatement of the collateral source rule, along with the right to subrogation in all states which have eliminated that rule.

8. Opening the National Practitioners' Data Bank to the public, in its entirety. And creating an on-line inquiry system to allow easy access for consumers.
9. Closing the reporting loopholes in the National Practitioners Data Bank which currently allow doctors to remove their names from malpractice case settlements involving hospitals and managed care plans.
10. Outlawing secrecy agreements.
11. Mandating medical malpractice insurance coverage, (the minimum amount of coverage, to be determined) as a condition of licensure for all physicians.
12. Community-rating of malpractice premiums so that the costs are spread more equitably among the specialties.
13. A minimum 3 1/2 year statute of limitation for filing malpractice lawsuits. That statute would be extended in cases where there has been continuous treatment, late discovery, suppression of information or criminal coverup. (This statute would not apply to minors.)
14. Mandatory audits for all medical malpractice insurance carriers (once every three years) so that premium rates can be appropriately adjusted. These audits would also be required PRIOR to any state granting premium increase requests.
15. Federal minimum standards for all State Medical Boards (see attached Federal Model prepared by CPR.)



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MODEL FOR STATE MEDICAL BOARD MINIMUM STANDARDS

In order to improve physician discipline and protect the public from harm, the Federal government should enact the following minimum requirements for all state medical boards (in alphabetical order):

1. **Board Composition:**

All Boards shall be composed of a majority of public members (at least 51%, preferably two-thirds). The Chairperson and Vice-Chair of the Board shall be public members. The size of the Board shall be based on the state's physician population (to be determined). Physician Board members shall be appointed by the Governor based solely on recommendations not nominations from a variety of recognized medical and non-medical sources (to be determined). Board members shall serve a term of no longer than 3 years (with one consecutive term).

2. **Consent Agreements:**

Boards shall prohibit plea bargains or consent agreements unless the physician agrees to plead guilty to the most serious allegation. Boards shall prohibit such agreements in negligence and incompetence-related cases unless the physician agrees to plead guilty to the most serious allegation and surrender his or her license.

3. **Consumer Protection Unit:**

Boards shall create a special Consumer Protection Unit which will consist of consumer protection officers with medical or social work background to deal directly with victim complainants. And all victim complainants shall be granted statutory immunity from liability, for libel, defamation, etc.

4. **Disciplinary Hearings:**

Board disciplinary hearings shall be open to the public, and all hearings shall adhere to a specified time frame (to be determined).

5. **Funding:**

Boards shall be allotted adequate funding in order hire the caliber of investigators, prosecutors and support staff necessary to effectively oversee the profession (and may raise physician fees to do so). All physician licensure and registration fees, and any reserves, shall be dedicated for exclusive use by the medical board. These funds may not be touched by a state for ANY reason other than the prescribed ones.

6. Impaired Physicians:

Boards shall establish an Impaired Physician Program (based on a model to be developed), and shall maintain jurisdiction over that program. Boards shall conduct an annual audit of the Impaired Physician Program and make the findings publicly available.

7. Informal Actions:

Boards shall share information about informal actions, such as letters of warning, with other jurisdictions.

8. Investigators:

Boards shall upgrade the salary and qualifications for complaint investigators (2/3's of whom shall have medical background).

9. Licensure:

Boards shall be responsible for both licensure and discipline of physicians.

Grounds for denial of licensure shall include the following:

- a. Any act or conduct which would constitute grounds for medical misconduct in the state in which the physician is applying.
- b. Any disciplinary action taken in another jurisdiction, which would constitute grounds for medical misconduct in the state in which the physician is applying.
- c. Any PENDING disciplinary investigation or action in another jurisdiction.
- d. Loss of hospital privileges in another jurisdiction.
- e. Malpractice lawsuits in another jurisdiction indicating that the doctor presents a risk.

10. License Restorations:

Boards shall require that any physician who has lost a license (as a result of surrender or revocation), wait a minimum of 5 years before applying for reinstatement of license, and must provide proof of on-going medical and remedial training (the parameters for which are to be determined).

11. Malpractice Insurance:

Boards shall require doctors to carry malpractice insurance as a condition of licensure. The amount of coverage shall be determined by the specialty. Physicians who perform surgery, but DO NOT have hospital privileges shall carry the same minimum coverage as physicians with hospital privileges.

12. Malpractice Data Unit:

Boards shall create a Malpractice Data Unit. This unit will be responsible for collecting all malpractice data statewide, and reviewing all malpractice claims to determine if they warrant further investigation for possible medical misconduct. This unit will also be responsible for developing a system that will flag physicians with an abnormally high number of malpractice claims or payouts. Doctors who fit these "outlier" profiles (which should be based on the size and scope of a doctor's practice, the specialty, and other risk-adjusted factors) would be subject to an automatic full-scale investigation.

13. Mandatory Reporting:

Boards shall require mandatory reporting of violations or dangerous practices by all licensees (including self-reporting by the licensee committing violation), courts, hospitals (staff and administration), all other health care providers (including HMO's clinics, etc.), liability insurance carriers, state and local medical societies and associations, state and local professional societies, other state agencies, PRO's, other health care professions, and federal agencies. All states shall impose severe civil penalties for failure to report.

Boards shall assure confidentiality to those reporting to the Board in good faith on possible violations. Board members, Board staff, individuals, and organizations required by law to report shall be granted immunity from prosecution and suit.

Liability carriers and self-insured entities must report all claims, and all payments including the dollar amount.

14. Misconduct Definitions:

Boards shall adopt uniform definitions of medical misconduct (based on a compilation of the strongest current state medical misconduct definitions).

15. Out-of-State Actions:

Boards shall not conduct a new hearing on any action taken by another jurisdiction, but shall only determine the appropriate disciplinary sanction to be imposed based on that out-of-state action. That sanction shall, at a minimum, be equivalent to the original sanction imposed.

16. Permanent Loss of License:

Boards shall permanently revoke the license of any physician convicted of medicaid/medicare fraud, fraudulent billing, child sex abuse, other sex abuse, murder (and other criminal acts, to be determined); or found guilty of falsifying or, in any way, altering medical records to conceal malpractice or other wrongdoing.

17. Physician Discipline Oversight Panel:

Boards shall establish a Discipline Oversight Panel to assess the physician discipline system. The panel shall consist of seven members appointed by the governor and may include no more than two physicians and one attorney.

(17. continued)

The panel members shall serve as individuals not as representatives of any organization, institution, agency or group. Panel members shall not participate in or review pending matters, but will review final determinations to assess the quality of work and whether the decisions are in the public interest. The panel shall assess the overall goals and objectives of physician discipline; how well the goal are being met; and whether and to what degree the process serves to minimize or deter medical misconduct. The panel may consult with medical and specialty societies, consumer organizations, other governmental organizations, state organizations, federal organizations and other states in its analysis and deliberations.

This panel shall also handle complainant appeals of cases dismissed by the Board without action.

18. Physician self-referrals:

Boards shall prohibit the practice which allows treating doctors to refer patients to clinics, labs, or other health care-related facilities or services in which that doctor, or his or her immediate family, has a financial interest. Any violation shall constitute grounds for medical misconduct. Any physician who currently self-refers shall have one year to comply with the statute.

19. Public Information and Outreach:

Boards shall have a public information officer responsible for organizing consumer and physician outreach and education programs, to include: development of a quarterly newsletter, information brochures, public serve announcements, and other outreach efforts to community groups, organizations, agencies, etc.

Boards shall set-up (and adequately staff) toll-free hotlines for consumer complaints and physician background checks. Anyone calling to check on a doctor shall automatically be entitled to the following physician "profile" information: date physician was first licensed; educational background; registration status; hospital affiliations; other states in which the doctor holds a license; the number of closed complaints against the physician (regardless of whether or not an action was taken); any formal charges pending against the physician; any disciplinary action taken against the physician's license (including a brief explanation about the basis for the action). This profile may be mailed to consumers upon request. After the federal government enacts legislation to open up the National Practitioners' Data Bank, callers will also automatically be given the Data Bank's toll-free number.

Boards shall issue an annual report made available to the public, media, legislature and other state officials. The report should contain information on licensure, including: # of applications received, licenses granted, licensure hearings, denials, temporary licenses, etc.

(19. continued)

The report shall also contain disciplinary information, including: # of complaints received (plus the source, status, category), # of actions taken, category of action; types of penalties; aggregate information about informal actions taken, etc. (Full list of items, to be developed.)

20. Recredentialing:

Boards shall require doctors to be recredentialed every 5 years as a condition of licensure. Doctors who have been involved in lawsuits or other disciplinary actions during any interim period, would be required to undergo a "clinical" performance evaluation as part of their recredentialing.

Doctors who practice exclusively in private office settings would also be required to undergo clinical performance evaluations and patient chart reviews for recredentialing.

21. Standard of Proof:

Boards shall require that the standard of proof in disciplinary actions be a preponderance of the evidence ONLY. No other standard will be acceptable.

22. Subpoena Power:

Boards shall have full subpoena power.

23. Summary Suspensions:

Boards shall have the power to issue summary suspensions which will run until a hearing can be promptly scheduled.

Mr. BROOKS. Doctor.

**STATEMENT OF ANTONIO FALCON, M.D., ON BEHALF OF THE
HEALTH CARE LIABILITY ALLIANCE**

Dr. FALCON. Mr. Chairman.

Mr. BROOKS. Glad to have you.

Dr. FALCON. Thank you very much for this opportunity, sir. My name is Antonio Falcon and I am a 1977 graduate of Baylor College of Medicine. I am a residency trained, board-certified family physician from the lower Rio Grande Valley of Texas.

Our medical practice is in Stark County, the second poorest county in the United States. Our patient profile is approximately 80 percent medicaid, 12 percent indigent, and 8 percent private pay. We are the only health care providers of obstetrics in a three-county area that is at least the size of Rhode Island and possibly bigger.

My partners and I deliver about 1,100 babies a year. Stark County borders with Mexico and our practice takes care of a lot of illegal immigrants. The combination of the above factors and the Rio Grande Valley being one of the medical malpractice hot spots of the country allow me to offer a unique perspective on the current tort system in this country.

The system is broken. Victims who should be compensated fairly are being robbed of money intended for them. Attached to my written statement is a settlement agreement that is an outrageous example of a system gone bad. In a \$200,000 settlement on a cerebral palsy case that one of the local doctors decided not to contest, called the insurance company and said, take care of my patient, the attorneys walked away with \$160,000. How can anyone fathom that a few hours of time is worth that kind of money? Whatever happened to somebody saying, this is too much money, let me let your child take some of it?

In another case in our area, an attorney dressed as clergy to solicit clients in an awful accident. I cannot imagine anyone stooping so low. In another case, a body was actually taken out of a cemetery and transferred to our community for a change of venue. How can anyone rip the family that lives 5,000 miles away for support just for a change of venue case?

The system, at least as I know it in Texas, has gone crazy and the Federal Government must intervene.

The President in his State of the Union mentioned that health care costs must be curtailed in order to control the deficit, and I tell you that liability costs must be curtailed in order to control medical costs. We have another outrageous example that is sometimes humorous of some of the abuse that occurs.

I had a medical malpractice case filed against me on a birth-related injury that was later dropped. The expert that was used was a retired nuclear radiologist who had done 6 weeks of obstetrics 32 years prior to the case. This man didn't have the opportunity to testify against me because he was picked up by the Board of Medical Examiners for peddling drugs.

Texas is one of the leading States in the country in disciplining bad doctors, and I personally am involved in that, working with the State licensing board. We have stopped many doctors from practicing.

ing medicine in Texas. I wish the trial bar would stop using them as expert witnesses.

Last spring my partners and I decided that we had had enough of lawsuits. I had practiced 11 years without a single lawsuit and all of a sudden, after the workmen's compensation laws in Texas changed, I was faced with four lawsuits.

My partners and I decided that we were going to drop our obstetrical care. We knew that this was going to leave a huge area of Texas without care, but there was just too much pressure on us. We decided that we were beaten.

The Federal Government intervened at that time. The locally funded community health center, under the help of Mr. Jose Camancho, came in and offered the Federal Tort Claim Protection Act and after many hours of negotiation, we were able to continue obstetrical practices without any loss of care to our patients.

We work under that system right now.

One last issue that I would like to address to you is the care of illegal immigrants along the border of this country. We need to be—right now the care of illegal immigrants is covered under emergency medicaid.

If there is no coverage for this type of patient, hospitals and providers will be devastated along our borders. I ask you to please consider some kind of safety net for the care of these patients for the sake of continuing to keep our hospitals and our practitioners in practice.

Mr. Chairman, the system, I feel, is broken. I will be available to answer questions and specifically I would like to address the Harvard study later if someone would like for me to do so.

Mr. BROOKS. Thank you very much.

[The prepared statement of Dr. Falcon follows:]

STATEMENT
of the
HEALTH CARE LIABILITY ALLIANCE

to the
Committee on the Judiciary
Subcommittee on Economic and Commercial Law
United States House of Representatives

Presented by
Antonio Falcon, MD
Family Practice Center
Rio Grande City, Texas

H.R. 3600 - The Health Security Act:
Issues Relating to Health Care Liability

June 22, 1994

Mr. Chairman and Members of the Committee:

My name is Antonio Falcon. I am a board certified family physician from the lower Rio Grande valley in Texas. My partners and I are the only providers of obstetrical services in a three county area, roughly the size of Rhode Island. Our patient population is 80% Medicaid, 12% indigent and 8% private pay or private insurance. We deliver approximately 1,100 babies every year. If not for the tort protection extended by Congress to physicians practicing in federally funded Community and Migrant Health Centers, we would not be practicing obstetrics at all.

I am a 1977 graduate of Baylor College of Medicine and a member of the American Medical Association and the Texas Medical Association. Last summer, I had the privilege of meeting with the Clinton Administration's Health Care Task Force to talk about my experiences with the liability system. On behalf of the Health Care Liability Alliance and

myself, I am pleased to have this opportunity to testify regarding the need for medical liability reform as a necessary component of comprehensive health system reform.

The Health Care Liability Alliance (HCLA) is a coalition of health care providers, insurers, health service organizations, manufacturers and individuals who believe that our country's dysfunctional system for resolving health care liability disputes is a national problem that demands a national solution. HCLA members have come together with the common purpose of calling for the inclusion of health care liability reform in federal health care reform legislation (An HCLA membership list is attached as Appendix A).

As the *1994 Physician Payment Review Commission (PPRC) Annual Report to Congress* -- and many reports before it -- make clear, the current system for compensating patients who have been injured in the course of receiving health care services is broken and should be repaired at the national level. (The PPRC Report is attached as Appendix B.) The system is inefficient and wasteful, contributes to problems with patient access to obstetric care and other specialty services, produces unfair and inconsistent outcomes, and benefits lawyers more than it does injured plaintiffs.

Unless changes are made in our liability laws, health care costs will continue to rise and access to health products and services will continue to be unnecessarily constrained. Medical malpractice premiums were the fastest growing component of physicians' practice costs in the 1980s. Driven by sharp increases in the frequency of claims and the average malpractice award in the early 1980s, malpractice premiums grew at twice the rate of medical inflation. Following a plateau in the growth cycle at the end of that decade, frequency and average award magnitude began to climb again in the early 1990s. My

own experience confirms these national trends. Prior to the 1990s, I had practiced 11 years without a single lawsuit, when suddenly I was faced with four claims at the same time. In Texas, claim frequency increased every year between 1983 and 1992 except one (1989), with dramatic increases since 1990. Total claims against physicians rose 21 percent in 1991 and another 23 percent in 1992. Based on past experience, it is likely that more than 70 percent of these claims will be closed with no indemnity payment. After analyzing this data, a new report from the Texas Medical Association (attached as Appendix C) has declared eleven counties in that state to be "disaster areas" due to sharp increases in award frequency and average magnitude in recent years.

Premiums are following these key indicators upward. For example, malpractice premiums increased by 14% in New York in 1993, and the largest New York insurance carrier has applied to the state's Insurance Commission for a 19% increase in 1994. Several other states also have imposed or are preparing to impose double digit increases in 1994.

Members of the HCLA believe that liability reform should apply equally to all potential defendants in personal injury cases arising from the delivery of health care services. Physicians will continue to practice "defensive" medicine or be reluctant to provide treatment to patients in those areas of medicine that are plagued by lawsuits. Life-saving drugs and medical devices will be slow in emerging and will either cost more, or become completely unavailable. Health care costs will increase as managed care plans -- increasingly targeted as the "deepest pocket" of all defendants -- feel constrained to pay for unproven or experimental treatments rather than run the risk of multi-million dollar awards.

For these reasons, members of the HCLA believe that national health care reform will not be effective unless it includes broad-based liability reform applicable in all medical malpractice claims arising from the delivery of health care services. Reform should apply whether the defendants are physicians, nurses, hospitals, pharmaceutical and medical device makers and distributors, managed care organizations or others. Twenty years of experience in the states has produced valuable information upon which to craft federal policy. In particular, California's Medical Injury Compensation Reform Act (MICRA), in place since 1975, has proven to be an effective model, and therefore is the basis of the legislative package supported by all HCLA members.

DEFINING THE PROBLEM

The United States has the world's most expensive tort system. At 2.3 percent of Gross Domestic Product, U.S. tort costs are substantially higher than that of any country and two and a half times the average of all developed countries. (*Tort Cost Trends, An International Perspective*, Tillinghast 1992.) The U.S. tort system cost \$132 billion in 1992. Between 1933 and 1991, U.S. tort costs rose by a factor of almost 400. By contrast, U.S. economic output (GNP) grew only one hundredfold over the same period. Thus, tort costs have grown almost four times faster than the U.S. economy over the past 58 years, according to Tillinghast.

Despite the magnitude of spending, our tort system functions very poorly in meeting its twin objectives of compensating victims and improving patient safety by deterring careless or wrongful behavior. No where is this truer than in what the RAND Corporation has accurately dubbed the "high stakes" world of medical liability and product liability litigation.

(*Trends in Tort Litigation: The Story Behind the Statistics*. RAND R-3583-1CJ. 1987.) For many years this country has grappled with the growing inability of the civil justice system to resolve health care liability claims in a fair, timely and cost effective manner.

Health Care Liability: A Public Concern

Americans want reform and are frustrated by the failure of lawmakers in most states to take effective action. They increasingly look to the Congress for leadership. I can assure you that without Congressional action to shield our practice from non-meritorious suits, my partners and I would not be delivering babies today. Following a deluge of suits in the last few years, we decided after many hours of serious thought to give up this aspect of our practice. We knew that this action would cause a significant hardship to many of our patients, as we were the last obstetrics providers in our three county area. And yet the lawsuit pressure was too much, so we notified our patients and prepared to help them find alternatives. However, as the result of a new federal law that took affect in 1993, we discovered that we had another option. By providing all of our obstetrics services under the auspices of federally funded migrant health care centers, we were able to be covered by and defended under the Federal Tort Claims Act. This is what we do today.

People know the liability system is out of control. Every recent poll has demonstrated that the American public strongly supports effective medical liability reform as a component of health system reform. According to a 1991 Gallup Poll, 77 percent of Americans think malpractice lawsuits and awards are an important reason for the rising costs in health care. The Los Angeles Times found that given seven possible reasons for expensive health care in this country, people are most likely to name malpractice suits. A

1992 survey shows that 44 percent of the public believes that only about half of the plaintiffs in civil liability lawsuits have just cause to file suit. A growing number -- now a third of the population (34 percent) -- say that the majority of civil liability lawsuits can't be justified.

Many jurors also feel lawsuits are abused. In interviews with 269 jurors in the Northeast, Valerie Hans, a professor at the University of Delaware, says she was struck by the jurors' spontaneous referrals to "frivolous lawsuits" and "litigation explosion." The jurors' attitudes showed in their verdicts. The jurors agreed or strongly agreed with the following statements: There are too many frivolous lawsuits today (83%); people are too quick to sue (81%); and the threat of lawsuits is so prevalent today that it interferes with the development of new and useful products (57%). (See, Appendix E, for a humorous commentary on our society's litigious climate.)

The PPRC Report, the Harvard Medical Practice Study, and reports by the General Accounting Office (GAO) and the Department of Health and Human Services Task Force on Medical Malpractice and Insurance, just to name a few, concur with the following consensus: The current tort system, without modification, is unable to resolve liability claims cost-effectively and makes a haphazard contribution to deterring negligent behavior or improving the safety of health care.

Liability Reform Objectives are Clear

There is a broad consensus about the objectives of health care liability reform:

1. Patient Safety Should be Promoted.

The HCLA believes that any meaningful reform of the liability system must contain meaningful patient safeguards against malpractice or harm from medical products or services.

The health care community is committed to continuing efforts to reduce the incidence of injury and strongly supports reform efforts to promote patient safety and identify incompetent providers or unethical practices. Our efforts alone, however, are not enough to remedy the many harms that the current tort system perpetuates.

2. The System's Focus Should be Compensation for Injured Patients, not Lawyers.

People injured in the course of receiving health care treatment are entitled to fair and prompt compensation. No one disputes this. Unfortunately, the current tort system has failed the patient population.

A February 1991 study by Harvard School of Public Health of hospital admissions in 1984 shows that of the one percent of patients whose medical records indicated some negligent treatment, only 12.5% filed liability claims. Significantly, only half of those patients -- 6.25% -- received compensation from the tort liability system. (*Harvard Medical Practice Study*, Harvard School of Public Health, 1990.)

Other data show that even when patients pursue compensation, other parties to the system reap disproportionate benefits. The RAND Corporation estimates that only 43 cents of every dollar spent in medical liability or product liability litigation reaches injured patients. The remainder is spent on administrative "transaction" costs, largely attorneys fees and expenses.

When one actually compiles attorney fees and expenses, a clearer picture of whom the litigation system truly benefits emerges. Attached as Exhibit D to my testimony is a final judgment order confirming a settlement agreement which involved a \$200,000 cash payment to the plaintiffs (parents and injured minor), together with monthly payments for 20 years to

the minor. Of the \$200,000 cash payment, more than \$160,000 was paid to the plaintiffs' attorney in expenses and fees, with less than \$40,000 retained by the parties. This was not a case that went to trial. Nor was this a particularly complicated or drawn out case. Nor was this a case where compensation of this magnitude was necessary to attract a good attorney to take the case. Any system that compensates lawyers this handsomely for a few hours work is in serious need of adjustment. The HCLA favors a graduated schedule that reduces the contingency percentage in steps as the award grows higher, thereby ensuring that the most seriously injured patients keep more of their award. Analysis of medical liability cases closed in California in 1993 indicate that the state's graduated limits on attorney contingency fees resulted in patients keeping an additional \$9 million in compensation that would have otherwise gone to their attorneys. (*1993 Medical Malpractice Large Loss Trend Study*, Medical Underwriters of California, April 1994; see also, Appendix F, a 1989 Forbes article on the impact of excessive contingency fees on tort costs.)

3. The Patient/Provider Relationship Should be Strengthened, Not Impeded.

According to the Harvard Study, health care is completely safe for 99% of patients in hospitals. The health care liability system should be designed to target providers who engage in the one percent of cases that may involve unsafe or unethical practices. Instead, it currently creates an overall climate of fear and suspicion that impede the maintenance of trusting therapeutic relationships.

The average physician has a 37% chance of being sued at sometime in his or her career. This increases to 52% for a surgeon and 78% for an obstetrician. A compelling indicator of the current system's failure is the fact that *a physician's chance of being sued for*

medical liability bears little relation to whether he or she has been negligent. The Harvard data show that 80% of the claims for medical negligence filed in New York did *not* correspond with a negligent adverse event. These findings reinforce the GAO's estimate that nearly 60% of all claims filed against physicians are dismissed without a verdict, settlement, or any payment of compensation in the plaintiff's favor (*Medical Malpractice, Characteristics of Claims Closed in 1984*, U.S. General Accounting Office, 1987). These numbers show that the current tort system as it functions in most states is not effectively resolving medical liability claims or deterring medical negligence.

4. The Liability Component of Health Care Costs Should Be Contained.

We all bear the burden of the high health care liability costs paid by potential defendants, when these costs are passed on in the form of more expensive health care services. In assessing the full extent of liability costs, several component factors should be considered.

The first component is liability insurance premiums, which have been a significant factor in the increase in patient health care bills. In the 1980s, professional liability premiums were by far the fastest growing component of physicians' practice costs, increasing at an annual average rate of 15.1% between 1982 and 1989. (*The Cost of Medical Liability in the 1980s*, American Medical Association, 1992.) Estimates show that for each baby delivered in Florida, \$1,119 goes toward payment of liability insurance, and average premiums paid by self-employed physicians tripled in the 1980s. The cost is especially heavy for some high-risk specialists in certain states whose premiums have exceeded \$100,000 and approach as much as \$200,000 annually. The estimated annual cost of liability

insurance for physicians and health care facilities has been placed at more than \$9 billion in 1992 and continues to grow.

A second factor is the cost attributable to "defensive medicine," the term used to describe diagnostic tests and services motivated primarily by the fear of litigation and the perceived need to build a medical record that documents a health care professional's judgment. While difficult to precisely quantify, defensive attitudes and practices are real and entirely understandable when physicians have a 38% average chance (up to 78% for obstetricians) of incurring a claim regardless of the quality of care they provide. The AMA estimates that this practice added an additional \$15.1 billion to the cost of health care in 1989. Lewin-VHI estimates the combined cost of physicians' and hospitals' defensive practices to be as high as \$25 billion in 1991. (*Estimating the Costs of Defensive Medicine*, Lewin-VHI, 1993.) In an April 1994 study, the Hudson Institute's Competitiveness Center reported that liability premiums and defensive medical contributed \$450 per patient admitted to a large urban hospital in Indiana, representing an average of 5.3% of the patient's health care costs. (DM McIntosh, DC Murray, *Medical Malpractice Liability, An Agenda for Reform*, Hudson Institute, 1994.)

According to the Lewin-VHI report, comprehensive medical liability reform as a component of health care delivery system reform could save an estimated \$35.8 billion over the next five years by curbing premium cost and many defensive medical practices. The Lewin-VHI study predicts that tort reform savings will accrue at an accelerated rate as practice patterns begin to change.

The liability costs borne by makers of medicines and medical products contribute additional billions to the national health care bill. In 1990, \$10.8 billion was paid to claimants in all health care product liability cases in the U.S. -- and that does not include associated administrative and legal defense costs.

Adding these components together, the total cost of physicians' and hospitals' liability premiums, defensive medicine, and coverage for makers of medicines and medical devices, is more than \$45 billion annually.

A final cost factor that is potentially enormous, but has not yet been adequately measured, is the liability of managed care systems for their utilization review activities that restrict payment for health care services that patients demand. Recent verdicts and settlement reports suggest that payors who refuse to provide services may be exposed to multi-million dollar suits, even if the medical service demanded by the patient has not been proven effective and is clearly excluded by the terms of the managed care plan. (*See Patients' Lawyers Lead Insurers to Pay for Unproven Treatments*, New York Times, March 28, 1994, page A1, attached as Appendix G.) It is difficult to imagine any scenario in which cost containment initiatives can be successful, if the business risk in denying such benefits is a virtually unlimited jury verdict.

5. Medical Innovation Should be Encouraged not Derailed.

The threat of liability acts to inhibit medical innovation and deprives health care professionals of certain medicines and medical devices needed for optimal patient treatment. The threat of litigation prompted seven of eight pertussis vaccine manufacturers to withdraw from the market between 1960 and 1985, even though no sound scientific study has even

confirmed a cause and effect relationship between the vaccine and any adverse neurological reaction. To prevent a dangerous shortage of the vaccine, the federal government established a compensation fund financed by an increase in the cost of the vaccine. Excessive litigation costs were also the reason that the manufacturer of the morning sickness drug Bendectin withdrew its product from the market, even though there is no credible scientific evidence to this day linking it to birth defects. Patients suffer needlessly because no substitute therapy for morning sickness has been developed -- the product liability litigation risk is just too high.

6. Access to the Comprehensive Health Care Should be Promoted.

Perhaps the most serious societal harm caused by the liability system is reduced access to health care. Increasing premiums and the threat of liability have caused physicians to abandon practices and/or to stop providing certain services in various areas of the country.

I have already testified to my own experience, which is not unlike those of many other physicians treating the rural and urban poor. Almost one out of eight obstetrician/gynecologists (12%) has dropped obstetrical practice as a result of liability risks. (*Professional Liability and its Effects: Report of a 1990 Survey of ACOG's Membership*, American College of Obstetricians and Gynecologists, 1991.) More than a half million residents of rural counties are without any physicians who provide obstetric services. (*Health Care in Rural America*, Office of Technology Assessment, September 1990.) Nor is this phenomenon limited to rural areas. An example of this problem was presented by Senator Riegle (D-MI) while chairing a 1991 hearing on health system reform, when he indicated that his family was unable to remain with its obstetrician of choice because that

physician gave up obstetrics practice. This did not happen to a citizen in a rural community. It happened to a U.S. Senator in the District of Columbia (See also, Appendix I, a 1990 Southern Legislative Conference report detailing numerous liability related access problems in rural areas.)

I can personally verify that the high costs of liability are a significant factor in the decisions of many physicians, in Texas and across the country, to drop or retire from high risk specialty areas such as obstetrics. After many years of advocating reform, I am convinced that the serious access problem will not be remedied without strong national leadership.

Liability concerns are increasingly creating obstacles to the availability and affordability of medical devices as well. In response to hundreds of claims filed against them, E. I. DuPont Company is restricting the sale of its Teflon product to the makers of lithium batteries used to power heart pacemakers. Even though it had no role in designing the pacemaker device of the lithium batteries, because DuPont supplies a raw material it is included in the legal chain of responsibility. By virtue of their size a supplier like DuPont may have deeper pockets, and therefore may be more vulnerable to suit, than smaller companies who actually design or produce the product. For the same reason, DuPont and other companies are also restricting the sale of raw materials to manufacturers of jaw implants, artificial blood vessels, heart valves and sutures, among other devices. (*Implant Industry is Facing Cutback by Top Suppliers*, New York Times, April 24, 1994, page A1, attached as Appendix J.)

Until some reasonable limits are put on the liability exposure of defendants in health care injury cases -- limits that provide fair, but not unlimited compensation for injured patients -- these access problems will not be abated.

FEDERAL LEADERSHIP IS NEEDED

Every shareholder in the medical liability system has the opportunity and the responsibility to make the system work better. The health care community is actively carrying out its responsibility to identify and address high-risk of injury situations through a variety of patient safety and loss prevention programs in virtually every medical setting. Unfortunately, we can do little to remedy the waste in our country's tort system. We hope that other participants in the system will heed the call to participate in this effort. As the federal government fashions a nationwide overhaul of the health care delivery system, it should act to realize a viable and consistent solution to the panoply of issues raised by health care liability.

The litany of problems with the current tort system does not necessarily mean that the system must be abandoned. The HCLA believes that a fault-based system which would permit meritorious claims, screen out claims with no merit and lower transaction costs can work. Reforms such as those adopted in the state of California tell us that the current system can be improved through reform, and that moderate reform can produce dramatic effects by promoting settlement of valid claims, discouraging frivolous litigation, and reducing the time required for claims resolution and its associated costs.

Federal Preemptive Tort Reform

Federal preemptive tort reform represents a bold approach, but the only one that can advance a nationwide solution to this complex problem.

Virtually every health system reform bill introduced to date, including the Clinton Administration's Health Security Act (S. 1757/H.R. 3600) incorporates a federal preemptive liability reform title. (See Appendix K for a comparison of liability titles of major health system reform bills.) I had the privilege of being invited to speak to the Clinton Administration's Health Care Task Force, and told them about my experiences with the liability system in Texas. Although the President and the First Lady should be commended for including liability reform concepts in S. 1757, the liability reform sections of their bill fall short of actions needed to accomplish meaningful liability reform. I had hoped they would do more.

In any federal preemptive scheme, states should be left with substantial power to implement additional or alternative reform programs that are equally effective at meeting federal objectives, and to experiment with a wide variety of alternative dispute resolution approaches to injury compensation. State-based demonstration projects like those now underway in Maine and a handful of other states to evaluate the use of clinical practice parameters/guidelines in litigation should also be helpful in evaluating whether such guidelines can reduce liability costs.

Reform Provisions Supported by the HCLA.

The members of the HCLA agree that effective health care liability reform will not be achieved unless the reform provisions described below are adopted at the national level.

These provisions are based on California's MICRA legislation, in place in that state since 1975. The California model ensures full and fair compensation for all actual losses, yet limits costs through various controls exerted on the "lottery" aspects of the medical liability system, notably a ceiling on non-economic damages and graduated limits on attorney contingency fees as claimants' awards rise. After nearly 20 years of experience in California, we can confidently conclude that California's limits on costs in high stakes cases have stabilized medical liability expenses overall, despite a pattern of long term growth in the frequency of liability claims in the state.

1. Apply liability reform provisions to all potential defendants in disputes arising from injuries received in the course of health care services delivery. Many liability reform titles, including the Health Security Act, apply only to malpractice actions brought against health care professional and institutional providers. Yet the manufacturers of prescription drugs and medical devices, providers of blood and tissue services or products, and managed care organizations are all at risk of lawsuit as well when a patient is injured. It should also be noted that hospitals, clinics and other institutional providers are sued not just for malpractice, but for personal injury alleged to result from their distribution of medical devices, pharmaceutical and blood/tissue material. Addressing the liability problems in just one part of the health care sector may actually stimulate litigation in other parts which are then perceived to have "deeper pockets." This detrimentally impacts medical technology manufacturers by deterring the development of new innovative, cost effective products. For all of these reasons, the liability reform umbrella should encompass all potential defendants in claims arising from injuries experienced in the course of health care treatment.

2. \$250,000 Non-Economic Damages Ceiling. Limits on non-economic damages are the single most effective reform in containing medical liability premiums. according to a September 1993 report *Impact of Legal Reforms on Medical Malpractice Costs* by the OTA. Ceilings on non-economic damages do not in any way restrain the ability of a claimant to recover medical expenses, lost wages, rehabilitation costs or any other *economic* loss suffered as the result of a health care injury. It limits only those damages awarded for pain and suffering, loss of enjoyment and other intangible items. Based on the successful experience of California's MICRA legislation, HCLA members support a \$250,000 limit. By international standards, this is a generous ceiling. NO other country provides a benefit this high for non-economic damages.

3. Several Liability for Non-Economic Damages. Under the current rule in many states, a defendant that is responsible for as little as one percent of the total fault may be held financially accountable for the entire award. HCLA members agree that defendants should remain jointly liable to the plaintiff for all economic losses, but should be only individually liable for the portion of non-economic damages in fact attributable to their own acts or omissions. This compromise ensures that the plaintiff will be made whole for all out of pocket losses, yet takes a step toward establishing fairness and accountability between defendants.

4. Attorney Contingent Fee limitations. The contingency fee is meant to be the "poor man's key to the court house." However, the contingency fee system is not serving this function well. Most persons with small health care injury claims never get access to the civil justice system, because the contingency fee stimulates lawyers to be primarily interested

in the "big ticket" cases. The system would be improved if the attorney contingency fee were calculated with some "relative value," similar to what the Medicare system now imposes with respect to physician fees.

All of the major health system reform proposals limit the amount an attorney can recover as part of a malpractice award. However, HCLA members cannot support the Health Security Act's contingency fee section which limits the attorney fees to a flat one third of the award, merely preserving the *status quo*. HCLA supports California's contingent fee limit schedule: 40% of the first \$50,000, 33 and 1/3 % of the next \$50,000, 25 % of the next 500,000, and 15 % of any amount by which the recovery exceeds \$600,000.

5. Collateral Source Payments. This reform would permit any defendant to introduce evidence of any reimbursement received or due to be received by a claimant from health or disability insurers or others for losses resulting from an injury. Claimants are permitted to provide evidence of amounts paid to secure the collateral source benefit. Providers of collateral source benefits would not be allowed to subrogate. The Health Security Act's collateral source provision would actually *offset* the award by the amount of collateral source payments received by the claimant. HCLA members believe that the Health Security Act's is not as effective as our proposal to inform the jury of such collateral source payments prior to their deliberations.

6. Future Damage Awards. Future damage awards over \$50,000 should be paid periodically. The Health Security Act incorporates a periodic payment reform provision, but fails to establish a monetary threshold at which it would begin to apply.

7. Statute of Limitations. A uniform statute of limitations should be enacted that (i) establishes a standard rule that claims must be filed within one year from the date an injury is *discovered*, but (ii) provides an outside limit of three years from the date the injury *occurred*. Exceptions to these general rules allowing extra time should be made: (iii) for children under age six who may not be able to communicate the existence of an injury, and (iv) in the instance where a foreign body with no therapeutic purpose is left in a claimant's body and not discovered for many years.

HCLA Comments on the Health Security Act

The Health Security Act contains a number of additional reform concepts that may or may not be effective. We offer the following comments:

1. Alternative Dispute Resolution (ADR). The ADR section of the Health Security Act is expressly non-binding, presumably in deference to the cherished right of access to a jury trial. Yet, the central objective of ADR is to divert cases from litigation. This tension can only be addressed by giving parties to a health care injury dispute some incentive to voluntarily settle with the ADR decision and not pursue litigation. Two approaches should be implemented. First, the ADR decision must be admissible as evidence in court. The jury should be informed that the dispute already has been through some investigation or process and gives them the benefit of that process for their deliberation. Second, adopt a fee-shifting rule, whereby a claimant or defendant who rejects the ADR decision and goes forward is made responsible for the professional fees of the opposing parties if a result better than the ADR decision is not achieved. Finally, existing ADR provisions enacted by the states should not be preempted by federal law.

Many HCLA members believe that federal leadership in this area is best exercised by encouraging state or federal demonstration projects utilizing various ADR models. Because so little is clear presently as to the effectiveness of ADR, it may be appropriate to encourage state "laboratories" to try and evaluate different ADR approaches.

2. Practice Guidelines. The Health Security Act would establish a pilot program to encourage the use of clinical practice guidelines for the purpose of expediting the resolution of claims arising from care delivered in accordance with such guidelines. The HCLA would not oppose such demonstration projects, *so long as they require that practice guidelines be used exclusively as an affirmative defense by defendants in liability cases*. This approach is consistent with demonstration projects already underway in Maine and other states.

3. Certificate of Merit. Non-meritorious suits will be discouraged if plaintiffs are required to have a qualified expert submit an affidavit stating that there is a likely breach in the standard of care. In the Health Security Act, the plaintiff's claim must be supported by a qualified expert. The Act should be strengthened by requiring a separate affidavit for each defendant and a penalty for experts who file affidavits in bad faith.

4. Enterprise Liability Demonstration Project. The Health Security Act's "enterprise liability" proposal would immunize physicians, nurses and other individual health care providers from responsibility for their actions and shift liability exposure to the health services "plan." This would only shift the associated liability costs, and instead of reducing them, could lead to higher losses because of the "deep pocket" theory. The HCLA

adamantly opposes the authorization or expenditure of federal funds to encourage *mandatory* enterprise liability.

Patient Safety/Risk Management

Providing medical care today involves a complex system of persons and technology, each individual and component of which is necessary to bring about the safe and effective delivery of care to the patient. All of our activities aim at the common goal of improving patient health and preventing patient injury. All call upon us to examine what we do or fail to do, and how we do it. When problems are detected, solutions are developed and implemented.

Legislation designed to enhance patient safety must occupy a central role in medical liability reform. The members of the HCLA support a number of bills introduced in the 103rd Congress would implement this approach such as S. 1533/H.R. 3080, the "Affordable Health Care Now Act," introduced by Sen. Trent Lott (R-MS) and Rep. Robert H. Michel (R-IL). The HCLA supports the dedication of health care professional licensing fees to increase the effectiveness of state medical disciplinary boards. We also support the ability of states to enter into contracts with local professional societies to assist in investigating consumer complaints, which have the potential to significantly enhance the resources of licensing and disciplinary boards.

HCLA members remain committed to reducing the incidence of patient injury. In this context, we support required risk management training for health professionals and are proceeding with aggressive endeavors to restrict the ability of unethical physicians to practice medicine.

CONCLUSION

Mr. Chairman, our liability system needs to be fixed to meet the needs of injured patients who deserve to be fairly compensated, the health care sector, which is willing to assume its fair share of the responsibility for avoidable patient injury, and society, which needs to reduce transaction costs, eliminate windfall judgments, and assure that physicians can still offer medically necessary services in an atmosphere of fairness to all parties. You are in a unique position to make reform happen by putting pressure on all parties -- including the legal profession -- to make the system work better for both claimants and defendants.

I appreciate the opportunity to appear before the Committee and would be pleased to respond to questions.

Appendix A**HEALTH CARE LIABILITY ALLIANCE
MEMBER LIST (Companies & Associations)**

American Academy of Dermatology
American Academy of Ophthalmology
American Home Products Corporation
American Hospital Association
American Medical Association
AMA/Specialty Society Medical Liability Project
American Society of Healthcare Risk Managers
Biotechnology Industry Organization
Californians Allied for Patient Protection
Cooperative of American Physicians, Inc./ Mutual Protective Trust
Council of Community Blood Centers
The Doctors' Company
Health Insurance Association of America
Health Industry Manufacturers Association
Medical Protective Company
Medical Mutual Liability Insurance Society of Maryland
MEDMARC Insurance Company
MMI Companies, Inc.
National Association of Manufacturers
National Council of Community Hospitals
Pharmaceutical Research & Manufacturers of America
Physician Insurers Association of America
Physician Insurance Company of Michigan

[Note: The text of Dr. Falcon's Appendix B is too voluminous to include in the body of the hearing text. See Appendix 1.]

Mr. BROOKS. Dr. Keller.

**STATEMENT OF ROBERT B. KELLER, M.D., VICE CHAIRMAN,
PHYSICIAN PAYMENT REVIEW COMMISSION**

Dr. KELLER. Thank you, Mr. Chairman, Members of the committee, I am Robert Keller, an orthopedic surgeon from Belfast, Maine, and today I represent the Physician Payment Review Commission.

The Physician Payment Review Commission was created by the Congress in 1986 to advise it on issues related to physician payment in the medicare program. Its 1989 proposal for physician payment reform was enacted and was implemented in 1992.

The Congress' mandate to the commission was substantially broadened in 1990. One of its new charges was to advise on medical malpractice reform. Although the commission's membership includes physicians from several medical specialties and practice settings, a majority of the 13 members come from other backgrounds, including business, consumers, nursing, HMO organizations, and health economics.

The proposals of the commission, which are presented in this testimony, have the unanimous support of all members of the PPRC. We believe that the medical malpractice system needs to become more effective and efficient in limiting the rates of medical injuries and compensating injured patients. Reform should also address widespread concerns that the system promotes the practice of defensive medicine and impedes many efforts to improve the cost-effectiveness of health care.

The commission has outlined a malpractice system for the future that we should work toward. We also suggest some steps to improve the functioning of the current system.

A future malpractice system would have two components. First, an efficient administrative system to compensate patients who experience medical injuries, and second, a complementary system for monitoring quality and for designing and implementing measures to reduce the rate and numbers of injuries.

Separating decisions on compensation from review of quality of care would enable each to be accomplished by a system best suited to that purpose. This would permit patient compensation to be improved while increasing physicians' confidence in judgments of their quality of care.

This new system cannot be implemented at the present time because extensive development and experimentation are needed for key components, but initial steps should be taken now.

First, better data on medical injuries should be collected and employed to prevent injuries and to improve the quality of care. Second, alternative dispute resolution systems for compensating injured patients should be developed and tested. Third, more reliable standards for compensation and negligence should be formulated.

To immediately improve the functioning of the current system, the commission recommends the adoption of certain tort reforms. These include rationalizing damage awards by the adoption of reasonable schedules for noneconomic damages. Interim limits may be employed until a schedule is adopted.

Next, offset of award for collateral source payments, periodic payments of large awards, and assignment of punitive damages to

quality improvement activities. Additional recommendations include schedules for attorneys' contingency fees, thresholds for joint and several liability, and reduction of statutes of limitation for minors to a reasonable period of time.

The evidence does not yet justify requiring the use of certificates of merit or mandates for enterprise liability. Although tort reforms will not solve all of the problems in the malpractice system, they can make a significant contribution. Compensation would become more consistent and predictable and administrative costs would be reduced. The commission believes that the case is sufficiently compelling for Federal mandate.

Much attention is being focused on how practice guidelines are likely to be treated in the malpractice system. The commission believes it would be premature for the Federal Government to mandate that all States accord special legal status to practice guidelines. This conclusion is based in part on an empirical study sponsored by the commission.

The results of this study showed that practice guidelines are playing a modest but increasing role in litigation. Their effects seem to be positive overall. For example, one fourth of the plaintiffs' attorneys reported that in the past year, a practice guideline had influenced their decision not to take a case.

In the State of Maine, we are currently under a liability demonstration project using practice guidelines. The data at this point is not there to indicate if they will work or not, but it is a useful experiment that is ongoing.

The results of State experiments, such as ours, which accord special legal status to practice guidelines, should be assessed before proceeding further in this area.

Thank you.

Mr. BROOKS. Thank you very much, Doctor.

[The prepared statement of Dr. Keller follows:]

**Statement On Medical Malpractice Reform
before the Subcommittee on Economic and Commercial Law
Committee on the Judiciary
United States House of Representatives**

June 22, 1994

by

**Robert B. Keller, M.D., Vice Chairman
Physician Payment Review Commission**

I am pleased to appear before this subcommittee on behalf of the Physician Payment Review Commission. The Commission was established by the Congress in 1986 to provide advice and recommendations on methods to reform payment to physicians under the Medicare program. The Commission's work helped pave the way for the Medicare physician payment reforms enacted in 1989 and implemented in 1992. The Congress subsequently expanded the Commission's mandate to include a wide range of health policy issues, including medical malpractice reform. The Commission submits a series of reports to the Congress each year, the most comprehensive being its annual report which you received on March 31.

During the past four years, the Commission has conducted an extensive analysis of the medical malpractice problem and explored a range of ideas for reform. It also commissioned the first empirical research to be conducted on the role of practice guidelines in malpractice litigation. The Commission appreciates the opportunity to summarize the results of its work on this topic. Additional details and supporting documentation can be found in a chapter on medical malpractice reform in our 1994 Annual Report to Congress.

The problems with the malpractice system have received widespread attention. Although medical care in the United States is generally of high quality, the incidence of preventable medical injury is greater than acceptable. Few patients who are negligently injured are

compensated, and the awards are variable. The existing malpractice system promotes the practice of defensive medicine and impedes efforts to improve the cost effectiveness of care. Further, the system's inefficiency results in high administrative costs and long delays in claims resolution. The goals of reform are to address these deficiencies.

The Commission has formulated a set of recommendations that include specific tort reforms to improve immediately the functioning of the current system. In addition, the Commission has identified steps that should be taken in the near term to pave the way for more fundamental reform of the malpractice system in the future. Tort reforms are discussed first, followed by an analysis of the role of practice guidelines in malpractice litigation. A future malpractice system envisioned by the Commission is then described, along with recommendations for beginning work on the building blocks of this system. These include better systems to prevent medical injuries, administrative systems for handling malpractice claims, and alternative standards for the compensation of medical injuries.

TORT REFORMS

Tort reforms are changes in the legal rules governing malpractice lawsuits. The Commission recommends certain of these reforms to improve the functioning of the current system. They would make damage awards more consistent and predictable, speed the settlement of cases, direct more resources to compensate injured patients, and reduce the occurrence of inappropriate and excessive awards. While some versions of tort reforms have the potential to inappropriately disadvantage injured patients, the Commission has taken care to formulate its tort reform recommendations so as to improve the system's fairness overall.

Schedules for Noneconomic Damages

Reasonable schedules should be developed for noneconomic damages. Much of the unpredictability and inconsistency that characterize today's malpractice awards are because of noneconomic damages (i.e., pain and suffering), which account for about 50 percent of total payments. Reducing the subjectivity of noneconomic damages and eliminating the potential for unreasonably high awards would improve decisionmaking during the course of a lawsuit and promote settlement.

The schedules would set acceptable ranges for awards for carefully defined categories of injuries. Schedules would establish a different limit for each grade of injuries, which is preferable to a single absolute limit that may be too high for some injuries and too low for others. Until a schedule is developed, however, it may be necessary to adopt a single interim absolute limit on noneconomic damages.

Schedules for Attorneys' Contingency Fees

The typical contingency fee paid to the claimant's attorney out of an award is about one-third of the recovery. A sliding-scale schedule for contingency fees would better approximate the fee to the work performed by the lawyer, so that more of a large award goes to the injured patient.

Modification of the Collateral Source Rule

This reform would limit the potential for "double recoveries" by some plaintiffs and thus would reduce the cost of the system without inappropriately harming plaintiffs.

Restrictions on Joint and Several Liability

Thresholds should be adopted for the application of joint and several liability. In cases with more than one defendant, the doctrine of joint and several liability holds any defendant responsible for the full award if any other defendants cannot pay their shares apportioned by fault. Practitioners and entities with adequate insurance or resources to pay malpractice awards do not want to pay the full amount of an award when their contribution to fault is minor or negligible, and the potential for liability out of proportion to fault encourages defensive medicine. But limits on joint and several liability may come at the expense of adequately compensating injured patients. The Commission recommends that a balance be struck by adopting thresholds for the application of joint and several liability.

Periodic Payments of Large Awards

More than half the states require that larger awards for future damages be paid in installments over time. The Commission recommends periodic payment for large awards. This would ensure that adequate resources are available to meet future needs.

Reductions in Long Statutes of Limitation

Overly long statutes of limitation create uncertainty, delay, and expense in insuring against malpractice claims. Birth-related injuries are the principal source of problems. Eight years is a safe period to allow detection of perinatal injury, and shorter periods are defensible. States that have longer statutes of limitations for minors should be required to reduce them to eight years at most.

Punitive Damages

Part or all of punitive damages awards should be diverted to quality improvement activities. Punitive damages, by definition, are not compensatory in nature. Their purpose is to deter others from similar conduct, thus protecting future patients from injury. This end would be furthered if the money from these awards were used directly for injury prevention or quality improvement activities.

OTHER PROPOSALS FOR TORT REFORMS

Some other proposed tort reforms have promise, but current knowledge of their effectiveness is not sufficient to justify that they be federally mandated. These include a certificate of merit requirement and a mandate for enterprise liability.

Certificate of Merit

A certificate of merit is a requirement that an independent medical expert review the medical record and certify that a claim is worthy before a formal lawsuit can be filed. It is often difficult to judge at a case's inception whether it is likely to be successful because key information is not available in the medical record. If the requirements for determining merit are loosened to respond to this problem, it will simply add another step to the litigation process, consuming time and money. This may be a barrier to some meritorious claims being brought, particularly for low-income plaintiffs who would have to incur the additional costs of this initial evaluation. If the certificate of merit requirement is too strict, some cases that eventually would be successful might be screened out simply because of incomplete information. Although the idea has promise, more needs to be learned about how to make certificate of merit programs work well before they are federally mandated.

Enterprise Liability

Under enterprise liability, a health care organization assumes financial responsibility for all negligent injuries to patients under its care, thereby relieving individual practitioners of any personal tort liability for such injuries. This is thought to save administrative costs and to better focus efforts to prevent injuries. It is presently working well for hospitals owned and staffed by one organization. As vertical integration spreads through the delivery system, enterprise liability is likely to follow naturally for reasons of efficiency. Although the trend toward enterprise liability is encouraging, the Commission considers it unwise to impose enterprise liability on

organizations and physicians that are not sufficiently integrated for the policy to work well: e.g., third-party indemnity payers and independent fee-for-service physicians.

THE ROLE OF PRACTICE GUIDELINES IN MALPRACTICE LITIGATION

Practice guidelines are a key element of the nation's efforts to improve the quality and cost-effectiveness of medical care. How guidelines are treated in the malpractice system has important implications for their success. Practice guidelines may help to improve the functioning of the malpractice system. This is because guidelines can make clear the applicable standard of care, which is a troublesome issue in many malpractice cases. They might lessen the need for expert testimony on the standard of care, thus avoiding a battle of the experts. Guidelines may appropriately increase the amount of malpractice litigation by helping make clear to injured patients, their lawyers, or juries that a standard of care was breached, while reducing the number of meritless cases filed.

Several factors, however, might prevent practice guidelines from improving the functioning of the malpractice system. The topics on which guidelines are being developed probably are irrelevant to the circumstances leading to most malpractice claims. Guidelines might be construed to create a firm standard of care when one is neither intended nor appropriate. While practice guidelines could provide an important legal support for physicians and health care organizations that use them, their revision by the judicial system could render guidelines ineffective in helping to control costs and improve quality. Such revisions could take two forms: an explicit rejection of the content of the guideline, or a carving-out of exceptions that effectively vitiates it. In addition, increased litigation might result from questioning the validity of guidelines or the

circumstances under which exceptions are warranted. In response to these concerns, some states, including Maine, have given practice guidelines special legal status to facilitate their use by defense attorneys, and thus encourage their use by physicians. No cases have been brought since these policies were enacted.

The Commission believes that the experience in these states should be assessed before the federal government would mandate that all states accord special legal status to practice guidelines. Particular attention should be paid to whether these actions have promoted or impeded the appropriate use of guidelines in litigation and in patient care. Until this information is obtained, it would be premature to proceed with a federal mandate. A recent study by the Commission, which I will describe in a moment, revealed nothing alarming about the current use of practice guidelines in malpractice litigation, so special legal protections may not be necessary. One would want to accord special status only to high-quality guidelines; the manner by which such guidelines are identified may itself confer the desired special weight in litigation. The asymmetry of some states' initiatives, in which only the defense can use practice guidelines, is problematic.

The Commission's Study of Practice Guidelines in Malpractice Litigation

Because little is known about the use of practice guidelines in malpractice litigation, the Commission engaged Harvard University researchers to conduct a study to provide empirical information on this topic. The study had three components. The first was a review of published judicial decisions that concern practice guidelines. The second was a review of malpractice claims files to determine how often guidelines were used in actual malpractice cases, and to

discover the ways they were used. The last was a survey mailed to a large sample of plaintiffs' and defendants' lawyers.

Several conclusions can be drawn from this study (the findings are described in detail in the Commission's Annual Report to Congress 1994). Practice guidelines are playing a modest but increasing role in malpractice litigation. About half of the malpractice attorneys surveyed had at least one case each year in which guidelines played a role, and a high proportion reported that the use of guidelines was increasing. Still, only 7 percent of the 259 claims reviewed from the malpractice insurers' files involved the use of guidelines. Obstetric guidelines are the ones most frequently being used, probably because they are among the oldest and best known to physicians and lawyers.

Guidelines are being introduced more often by plaintiff than by defense attorneys, possibly because guidelines may provide cheaper or stronger evidence of the standard of care than expert testimony. The use of guidelines by either side is usually, but not always, successful in malpractice litigation. In published judicial decisions, for example, plaintiffs won 17 of the 23 cases in which their lawyers used the practice guidelines, while in 6 of 9 cases a practice guideline was used successfully by the defense.

Guidelines helped lawyers, judges, and juries reach decisions. Of the attorneys representing plaintiffs, one-quarter stated that a guideline had influenced their decision not to take a case in the past year; one-quarter of all the attorneys noted that a guideline had influenced their decision to drop or settle a case. One-quarter also said that a guideline had influenced the decision of

a trier of fact (jury or judge) in at least one case during the preceding year. The lawyers did not report much change in the need for expert testimony.

Although the effects of guidelines on the litigation process are varied, overall they seem positive. Future monitoring and research are needed to assess whether guidelines are being used appropriately in court, including whether disputes about their applicability or content are troublesome. The results should inform how guidelines are derived and drafted.

DEVELOPING A FUTURE MALPRACTICE SYSTEM THAT WOULD BETTER ACHIEVE ITS GOALS

The tort reforms recommended by the Commission are essential to improve the existing malpractice system, but they are not sufficient to ameliorate all of its problems. Tort reform is unlikely, for example, to reduce substantially the practice of defensive medicine, improve the prevention of medical injuries, or compensate more of the negligently injured patients who are not compensated today. More fundamental changes are needed to accomplish these goals. These changes are embodied in a future malpractice system that the Commission has outlined.

The proposed system would have two components. One would be a fast, efficient administrative compensation mechanism that would provide adequate awards to patients who experience preventable medical injuries. The other would be a complementary system for monitoring, quality review, and design and implementation of measures to reduce the rate of injury. An important feature of the proposed system is that decisions about compensation and quality of care in individual cases would each be made by a process designed specifically for that purpose.

Clear criteria for compensability and for damages awards would be established, whereas judgments about quality of care would be made in forums better suited to make those determinations.

These components could be developed in an evolutionary manner. To pave the way for this system of the future, the Commission's recommendations focus on:

- improving systems to prevent injuries,
- developing and using efficient alternative dispute resolution systems for compensating injured patients, and
- formulating and testing more reliable standards for compensation decisions.

Preventing Medical Injuries

A systematic approach to injury prevention is likely to be most effective in reducing the rate of injury. The federal government should support a variety of initiatives that are needed to put a systematic approach into action. Effective injury reduction programs require the collection and analysis of data, as well as the design and implementation of effective interventions. Better data are needed to help detect preventable injuries and determine their causes. Early warning systems and active surveillance are needed to detect as many preventable injuries as possible, not just those that result in claims. The basic epidemiology of medical injuries should be delineated. Coding systems should be developed to permit this more abstract information to be entered into computerized databases. Because many events need to be collected and analyzed to detect patterns of rare events, local databases must be compatible to permit merging. Health

system reform may provide an opportunity for the development of standardized coding and databases.

Public Disclosure of Malpractice Data. One strategy that has been suggested to better protect patients from negligent injuries is to provide them with information about the malpractice experience of physicians and health plans. Consumers could be given access, for example, to the physician-specific information about malpractice payments contained in the National Practitioner Data Bank (NPDB), to which all malpractice payments made on behalf of physicians must be reported.

The Commission recommends against such disclosures at this time. The information would be of little help to the individual patient, and public disclosures would be likely to adversely affect the underlying processes that generate the information. There are reports that more physicians are refusing to settle cases in order to avoid being reported to the now-confidential NPDB. The incidence of defensive medicine -- particularly the avoidance of risks by refusal to provide high-risk services -- would likely be increased. The public would be better served if such information were used effectively by the quality assurance and oversight mechanisms of the profession and of state licensing boards.

Alternative Dispute Resolution Systems

Significant improvement in how malpractice claims are processed can occur only outside the courtroom. The Commission believes that better alternative dispute resolution (ADR) systems need to be developed and tested, however, before all claims should be required to be resolved

by ADR methods. Little is known about the efficacy of ADR in medical malpractice. The experience of some health plans with binding arbitration reportedly has been favorable, but at least one has discontinued arbitration because of a shortage of qualified arbitrators.

There are potential disadvantages to ADR. The quality of any ADR process depends heavily on the personnel involved. It is unlikely that enough high-quality ADR services would be available immediately if all medical malpractice cases had to use this technique. Finally, ADR systems may evoke counterproductive behavioral responses, which are difficult to predict in advance. For example, if final adjudicatory hearings are cheaper, easier, and faster than jury trials, more cases might proceed to such hearings, lengthening rather than shortening delays in compensation. Demonstrations and evaluations should be supported by the federal government to learn more about how ADR systems can best operate.

ADR must be binding to have a positive effect. Otherwise, it would merely impose additional delays and costs on an already slow and expensive litigation process. An ideal scenario would be the development of ADR systems advantageous to plaintiffs and defendants alike, so that both would voluntarily agree to using them and being bound by the result.

Alternative Standards for Compensation

The negligence standard does not appear to be a good guide to decisionmaking by providers and juries. More reliable standards for liability could possibly be developed. Such standards must be tested for their reliability and their effects on the number and size of claims paid. One standard that has been proposed is no-fault, which would compensate patients whose injuries

were caused by medical care, regardless of whether the care was substandard or not. The determination of eligibility for compensation would be simplified and made more reliable by dispensing with the need to determine the standard of care and whether it was breached. The principal fear raised by a no-fault system is that vastly larger numbers of injuries might become eligible for compensation. A no-fault standard should be tested first in a demonstration.

Another standard might be based on avoidability, to compensate patients for injuries that need not have occurred. Some errors in care are not negligent. For example, a mistake in considered professional judgement is often deemed not to be negligent. This standard would focus prevention efforts on the full range of preventable injuries, rather than just negligent ones. Fewer claims would be compensated than under no-fault. For example, a particular treatment may entail a known but unavoidable risk of serious injury or complication. Patients who experience an adverse outcome from that treatment would be compensated under a no-fault system, but not under a standard based on avoidability. This standard shares with no-fault the advantage of not conditioning compensation on a judgment about whether the care was substandard. Compensation for an injury would not itself mean that the care was substandard; that determination would need to be made through another mechanism better suited to that task. This could reduce inappropriate defensive medicine practices and improve providers' confidence in the system. It is probably easier to determine simply whether an injury was avoidable than whether failure to avoid was due to negligence, but there is no information on the reliability of a standard based on avoidability. Research is needed to develop and test such a standard.

Mr. BROOKS. Dr. Hannan.

STATEMENT OF DAVID T. HANNAN, M.D., MEDICAL SOCIETY OF THE STATE OF NEW YORK

Dr. HANNAN. Thank you, Mr. Chairman. Good morning. My name is Dr. David Hannan, I am a board-certified practicing family physician in Newark, NY, a village with approximately 10,000 residents which is located 30 miles east of Rochester, NY.

I currently serve as a member of the governing council of the Medical Society of the State of New York, and I am also chairman of our State Society's Federal Legislation Committee.

On behalf of the State society and its nearly 27,000 members, I thank you for allowing me the opportunity to speak with you today.

As one of the few remaining family physicians in New York State who continues to provide obstetrical services to my patients, and last year I delivered 80 babies, I believe I am as qualified as anyone to speak about our medical liability system, its impact on the practice of medicine, and the need for meaningful Federal tort reform.

Just last week in New York, the State insurance department announced a so-called stabilized rate increase for the 1994, 1995 premium year averaging 8 percent. This comes on top of last year's "stabilized rate" increase of 14 percent.

The authority to set these stabilized rates was established by the State legislature in 1986 in order to moderate excessively high liability premium increases.

According to the State's Superintendent of Insurance, however, the State's actuarial assessment of data supplied to the department by the State's medical liability insurance carriers justified rate increases of at least 20 percent for both last year and this year.

And, since under the law allowing for these so-called stabilized rates it is the physicians, not the insurers, nor the State, who are subject to a surcharge on their future premiums if there is any shortfall of funds. We believe strongly that physicians in New York State are merely living on borrowed time.

Even with the litany of reforms enacted during the mid-1980's, physicians in New York State now pay some of the highest medical liability premiums in the Nation with obstetricians on Long Island paying in excess of \$125,000 per year, and even those who practice in rural, upstate New York paying close to \$45,000 per year.

However, it is not only the actual premium dollars paid by physicians that must be taken into account when considering the need for reforming the medical liability system. There are indirect costs, attributable to defensive medicine, decreased access to care, and perhaps most important, the perpetuation of a system which pays on average less than 40 cents on the dollar to true victims of malpractice. All of these factors compel Congress to enact meaningful tort reforms now.

However, I must caution you that many of the reforms which are now being considered by Congress and that have been tried in New York State, while important, have simply not proven adequate to the overwhelming problem which the medical liability system has become.

I commend you to a report issued in September 1993 by the Congressional Office of Technology Assessment, entitled *Impact of Legal Reforms on Medical Malpractice Costs*. This report, which assessed various State approaches to medical liability reform, noted that collateral source payments have been shown to reduce certain medical liability cost indicators only slightly.

Restricted attorney fees, periodic payment of awards, and the use of certified standards of care have not adequately reduced malpractice costs. The report continues, however, by noting, quote, "The one reform consistently shown to reduce malpractice cost indicators is caps on damages," end quote.

I strongly urge members of this committee to examine this report which has been prepared at the request of the House Committee on Ways and Means and the Senate Committee on Labor and Human Resources.

Why then do I, and apparently the OTA, put such emphasis on the need for a cap on noneconomic damages? In the case of New York State, the cap is the only major component of reform which differentiates New York's reforms of the mid-1980's from California's landmark Medical Injury Compensation Reform Act of 1975, and the lack of a cap is also why in 1994, even with our State insurance department continuing to set a stabilized artificially controlled insurance premium, a pediatrician in New York pays more than twice as much as a pediatrician in California for the same amount of liability insurance.

The absence of a cap, furthermore, is also why many physicians in New York State and nationally continue to shy away from high-risk specialties and why one in six obstetricians and seven out of ten family physicians who had once practiced obstetrics have decided to discontinue providing obstetrical care.

Every time we fail to reform the current medical liability system, its inherent inequities worsen. Patients with legitimate claims but damages insufficient to appeal to the plaintiff's bar rarely find their way into the system. Compensation to the plaintiff is often delayed in an inordinate amount of time with the average case taking 7 to 10 years to settle.

More money is spent to pay attorneys, expert witnesses, and administrative costs than to actually compensate the victims of malpractice, and perhaps most important, the present system, with its emphasis on shock value and emotion, makes a mockery of our judicial system while at the same time continuously raising the sights of claimants and their lawyers in future cases, thereby further exacerbating the weaknesses inherent in our jury system.

At a time when our leaders are struggling to reform our Nation's health care delivery system, it has become increasingly clear that any effort to do so is destined to fail unless it incorporates meaningful reforms to address the inequitable and prohibitively expensive system by which we currently adjudicate cases and compensate victims involved in medical liability actions.

Thank you again, Mr. Chairman, for providing me the opportunity to share with you my thoughts on this pressing matter.

Mr. BROOKS. Thank you very much.

[The prepared statement of Dr. Hannan follows:]

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TESTIMONY OF THE
MEDICAL SOCIETY OF THE STATE OF NEW YORK
SUBMITTED TO
THE HOUSE OF REPRESENTATIVES
JUDICIARY COMMITTEE
SUBCOMMITTEE ON ECONOMIC
AND COMMERCIAL LAW

JUNE 22, 1994
WASHINGTON, D.C.

GOOD MORNING, MY NAME IS DAVID HANNAN, MD. I AM A BOARD-CERTIFIED, PRACTICING FAMILY PHYSICIAN IN NEWARK, NEW YORK, A VILLAGE WITH APPROXIMATELY 10,000 RESIDENTS WHICH IS LOCATED 30 MILES EAST OF ROCHESTER. I CURRENTLY SERVE AS A MEMBER OF THE GOVERNING COUNCIL OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK AND I AM ALSO CHAIRMAN OF OUR STATE SOCIETY'S FEDERAL LEGISLATION COMMITTEE. ON BEHALF OF THE STATE SOCIETY AND ITS NEARLY 27,000 MEMBERS, I THANK YOU FOR ALLOWING ME THE OPPORTUNITY TO SPEAK WITH YOU TODAY.

AS ONE OF THE FEW REMAINING FAMILY PHYSICIANS IN NEW YORK STATE WHO CONTINUES TO PROVIDE OBSTETRICAL SERVICES TO MY PATIENTS (LAST YEAR I DELIVERED 80 BABIES) I BELIEVE I AM AS QUALIFIED AS ANYONE TO SPEAK ABOUT OUR MEDICAL LIABILITY SYSTEM, ITS IMPACT ON THE PRACTICE OF MEDICINE AND THE NEED FOR MEANINGFUL FEDERAL TORT REFORM.

JUST LAST WEEK IN NEW YORK, THE STATE INSURANCE DEPARTMENT ANNOUNCED A "STABILIZED RATE INCREASE" FOR THE 1994-95 PREMIUM YEAR AVERAGING 8%. THIS COMES ON TOP OF LAST YEAR'S "STABILIZED RATE INCREASE" OF 14%. THE AUTHORITY TO SET THESE "STABILIZED RATES" WAS ESTABLISHED BY THE STATE LEGISLATURE IN 1986 IN ORDER TO MODERATE EXCESSIVELY HIGH LIABILITY PREMIUM INCREASES. ACCORDING TO THE STATE'S SUPERINTENDENT OF INSURANCE, HOWEVER, THE STATE'S ACTUARIAL ASSESSMENT OF DATA SUPPLIED TO THE DEPARTMENT BY THE STATE'S MEDICAL LIABILITY INSURANCE CARRIERS JUSTIFIED RATE INCREASES OF AT LEAST 20% FOR BOTH LAST YEAR AND THIS YEAR. AND, SINCE UNDER THE LAW ALLOWING FOR THESE "STABILIZED RATES" IT IS THE PHYSICIANS - NOT THE INSURERS, NOR THE STATE - WHO ARE SUBJECT TO A SURCHARGE ON FUTURE PREMIUMS IF THERE IS ANY SHORTFALL OF FUNDS WE BELIEVE STRONGLY THAT PHYSICIANS IN NEW YORK STATE ARE MERELY LIVING ON BORROWED TIME.

EVEN WITH THE LITANY OF REFORMS ENACTED DURING THE MID-1980'S, PHYSICIANS IN NEW YORK STATE NOW PAY SOME OF THE HIGHEST MEDICAL LIABILITY PREMIUMS IN THE NATION WITH OBSTETRICIANS ON LONG ISLAND PAYING IN EXCESS OF \$125,000 PER YEAR AND EVEN THOSE WHO PRACTICE IN RURAL, UPSTATE NEW YORK PAYING CLOSE TO \$45,000. HOWEVER, IT IS NOT ONLY THE ACTUAL PREMIUM-DOLLARS PAID BY PHYSICIANS THAT MUST BE TAKEN INTO ACCOUNT WHEN CONSIDERING THE NEED FOR REFORMING THE MEDICAL LIABILITY SYSTEM. INDIRECT COSTS, ATTRIBUTABLE TO DEFENSIVE MEDICINE; DECREASED ACCESS TO HEALTH CARE; AND, PERHAPS MOST IMPORTANT, THE PERPETUATION OF A SYSTEM WHICH PAYS ON AVERAGE LESS THAN FORTY CENTS ON THE DOLLAR TO TRUE VICTIMS OF

MALPRACTICE... ALL OF THESE FACTORS COMPEL CONGRESS TO ENACT MEANINGFUL TORT REFORMS NOW.

HOWEVER, I MUST CAUTION YOU THAT MANY OF THE REFORMS WHICH ARE NOW BEING CONSIDERED BY CONGRESS AND THAT HAVE BEEN TRIED IN NEW YORK STATE, WHILE IMPORTANT, HAVE SIMPLY NOT PROVEN ADEQUATE TO THE OVERWHELMING PROBLEM WHICH THE MEDICAL LIABILITY SYSTEM HAS BECOME.

I COMMEND TO YOU A REPORT ISSUED IN SEPTEMBER 1993 BY THE CONGRESSIONAL OFFICE OF TECHNOLOGY ASSESSMENT ENTITLED, "IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS". THIS REPORT, WHICH ASSESSED VARIOUS STATE APPROACHES TO MEDICAL LIABILITY REFORM, NOTED THAT COLLATERAL SOURCE PAYMENTS HAVE BEEN SHOWN TO REDUCE CERTAIN MEDICAL LIABILITY COST INDICATORS ONLY SLIGHTLY WHILE RESTRICTED ATTORNEY FEES, PERIODIC PAYMENT OF AWARDS AND THE USE OF CERTIFIED STANDARDS OF CARE HAVE NOT ADEQUATELY REDUCED MALPRACTICE COSTS. THE REPORT CONTINUES, HOWEVER, BY NOTING, (QUOTE) "THE ONE REFORM CONSISTENTLY SHOWN TO REDUCE MALPRACTICE COST INDICATORS IS CAPS ON DAMAGES." (CLOSE QUOTE) I STRONGLY URGE MEMBERS OF THIS COMMITTEE TO EXAMINE THIS REPORT WHICH WAS PREPARED AT THE REQUEST OF THE HOUSE COMMITTEE ON WAYS AND MEANS AND THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES.

WHY THEN DO I, AND APPARENTLY THE OTA, PUT SUCH EMPHASIS ON THE NEED FOR A CAP ON NON-ECONOMIC DAMAGES? IN THE CASE OF NEW YORK STATE, THE CAP IS THE ONLY MAJOR COMPONENT OF REFORM WHICH DIFFERENTIATES NEW YORK'S REFORMS OF THE MID-1980'S FROM

CALIFORNIA'S LANDMARK MEDICAL INJURY COMPENSATION REFORM ACT OF 1975 (MICRA); AND THE LACK OF A CAP IS ALSO WHY IN 1994, EVEN WITH OUR STATE INSURANCE DEPARTMENT CONTINUING TO SET A "STABILIZED", ARTIFICIALLY-CONTROLLED INSURANCE PREMIUM, A PEDIATRICIAN IN NEW YORK PAYS MORE THAN TWICE AS MUCH AS A PEDIATRICIAN IN CALIFORNIA FOR THE SAME AMOUNT OF LIABILITY INSURANCE. THE ABSENCE OF A CAP, FURTHERMORE, IS ALSO WHY MANY PHYSICIANS IN NEW YORK STATE AND NATIONALLY CONTINUE TO SHY AWAY FROM "HIGH-RISK" SPECIALTIES AND WHY ONE IN SIX OBSTETRICIANS AND 7 OUT OF 10 PHYSICIANS IN FAMILY PRACTICE WHO HAD EVER PRACTICED OBSTETRICS HAVE DECIDED TO DISCONTINUE PROVIDING OBSTETRICAL CARE. EVERY TIME WE FAIL TO REFORM THE CURRENT MEDICAL LIABILITY SYSTEM, ITS INHERENT INEQUITIES WORSEN. PATIENTS WITH LEGITIMATE CLAIMS BUT DAMAGES INSUFFICIENT TO APPEAL TO THE PLAINTIFF'S BAR RARELY FIND THEIR WAY INTO THE SYSTEM; COMPENSATION TO THE PLAINTIFF IS OFTEN DELAYED AN INORDINATE AMOUNT OF TIME WITH THE AVERAGE CASE TAKING 7 TO 10 YEARS TO SETTLE; MORE MONEY IS SPENT TO PAY ATTORNEYS, "EXPERT" WITNESSES AND ADMINISTRATIVE COSTS THAN TO COMPENSATE VICTIMS OF MALPRACTICE; AND, PERHAPS MOST IMPORTANT, THE PRESENT SYSTEM - WITH ITS EMPHASIS ON "SHOCK VALUE" AND EMOTION - MAKES A MOCKERY OF OUR JUDICIAL SYSTEM WHILE AT THE SAME TIME CONTINUOUSLY RAISING THE SIGHTS OF CLAIMANTS AND THEIR LAWYERS IN FUTURE CASES THEREBY FURTHER EXACERBATING THE WEAKNESSES INHERENT IN OUR JURY SYSTEM.

AT A TIME WHEN OUR LEADERS ARE STRUGGLING TO REFORM OUR NATION'S HEALTH CARE DELIVERY SYSTEM, IT HAS BECOME INCREASINGLY CLEAR THAT ANY EFFORT TO DO SO IS DESTINED TO FAIL UNLESS IT

INCORPORATES MEANINGFUL REFORMS TO ADDRESS THE INEQUITABLE AND PROHIBITIVELY EXPENSIVE SYSTEM BY WHICH WE CURRENTLY ADJUDICATE CASES AND COMPENSATE VICTIMS INVOLVED IN MEDICAL LIABILITY ACTIONS.

THANK YOU, AGAIN, FOR PROVIDING ME THE OPPORTUNITY TO SHARE WITH YOU MY THOUGHTS ON THIS PRESSING MATTER.

Mr. BROOKS. Now, some hold out the California medical malpractice reform, known as MICRA, as a model for Federal action, but how does this square with Mr. Keener's testimony as a malpractice defense lawyer that malpractice premiums have not diminished in California as a result of MICRA?

How do you square that? I think Mr. Corboy or Dr. Keller said it didn't go up anyhow. You didn't agree with that? What do you think about that, Dr. Hannan?

Dr. HANNAN. I think the medical malpractice premiums speak for themselves when you compare what the cost is in California compared to New York and the difference in the laws in the two States, that shows itself. There may be just as many suits—

Mr. BROOKS. Shows what?

Dr. HANNAN. It shows that the cost of settling cases and the awards to plaintiffs are higher in New York and therefore the cost to physicians of doing business, the cost of malpractice liability is higher in New York simply because of the difference in the laws between the two States.

Mr. BROOKS. But Mr. Keener thought that the restrictions under MICRA, which had many alleged reforms, didn't seem to function well.

Dr. HANNAN. Well, that certainly is not our position and we think the rates speak for themselves.

Mr. BROOKS. A recent Harvard medical practice study concluded that fewer than 2 percent of medical malpractice victims ever filed suit and an even smaller percentage ultimately recover any damages.

How can we increase access to justice for these 98 percent of people who have damages and never even file? Maybe it is a small damage or a big damage. I don't know. How do they get any coverage, Dr. Falcon?

Dr. FALCON. Yes, sir, that is why I say the system is broken.

Mr. BROOKS. The 98 percent slipped?

Dr. FALCON. That is right.

Mr. BROOKS. They didn't do anything.

Dr. FALCON. Yes, sir. Those numbers I think come from the Harvard study.

Mr. BROOKS. Yes, sir.

Dr. FALCON. And I would like to mention a couple of things on it. I have had the opportunity to review this and let me just tell you that I review it from the point of somebody who has done quality assurance in the State of Texas for 7 years.

This study was conducted in the State of New York. It is a 1994—I mean 1984 study. In medicine, 10 years is a long time. Things have changed tremendously since then. These are not practitioners. If you look at page 370 of their study, the nonpractitioners trained the physicians that reviewed the cases for evidence of adverse events and negligence, people that were nonpractitioners telling people what to look for and charge when it came to negligence, and let me tell you, it has been our experience in Texas that you cannot do—you have to have active practitioners reviewing those cases.

An adverse event in this study was defined as injuries caused by medical management. Ladies and gentlemen, under this study, if

we—if I gave you an aspirin while you were in the hospital and you developed an upset stomach, that was considered an adverse event, and that is not quality—

Mr. BROOKS. If you are allergic to aspirin like I am, it would be.

Dr. FALCON. I am not saying that it is not a problem. I am saying that that is not a quality problem. People are going to have reactions to medications. If a patient comes to me and says, I have a sore throat and I give them penicillin and they have a reaction, that is an adverse effect, especially if I didn't know they were allergic.

They are problems, but they are not problems that were caused by negligence.

The study involves 7,000 patients, and it has been our experience in the State of Texas that if you took 7,743 charts and reviewed them for quality issues, it would take five physicians working full time for 1 year to do that, and I don't know how much time Harvard took to do this, but that is a tremendous effort from a lot of physicians to do a lot of review.

The other thing that I would like to address about this study is that the way that the adverse events and negligence were described depended on two doctors that were reviewing charts, and it is interesting to note that board-certified internists and surgeons reviewed these cases and they talk about newborns with adverse effects.

Ladies and gentlemen, my children are taken care of by family doctors and pediatrician, not internists or surgeons, and so there is a lot of flaws in this study.

Mr. BROOKS. Any lawyers have any comment? Ms. Wittkin, do you have any comment on how they could get more protection for the people who never even file, who may suffer damages? They say 98 percent don't even file.

Ms. WITTKIN. Certainly. I think one of the issues that was brought up by Mr. Keener is something that we should look at.

I don't necessarily agree with the solution about how we get faster settlement of low-end cases or cases that aren't highly compensatable, but there is another way to do it, and that is to set up, within the alternative dispute resolution mechanism, some form of binding arbitration at the request of the plaintiff for cases worth under \$100,000.

That will do several things. It will allow the victims who have cases that are not highly compensable, but certainly meritorious and who are having great difficulty getting attorneys, an avenue of legal redress and it should be a swift avenue, it should be less expensive and it is something that I think we should look at, and I think that actually it is Senator Kennedy's health care bill has language about—

Mr. BROOKS. It is an interesting idea. Who would you have on an arbitration panel? Less than a \$100,000 damage and the lawyers make a deal. The plaintiff's lawyer gets \$30,000; it cost him \$20,000 to do the case and it takes a lot of time. He might make \$10,000, he might not make anything, so he doesn't want to do it. Defense lawyers make the same \$30,000, right?

Ms. WITTKIN. Defense lawyers make money hourly.

Mr. BROOKS. But I mean roughly. They would make about \$30,000, the plaintiff would make \$30,000 and the defense lawyers make about \$30,000, and the plaintiff, the damaged individual, might get 40 percent. We understand that.

Ms. WITTKIN. Yes.

Mr. BROOKS. Now, to avoid that, we want to have arbitration. Would you have doctors or lawyers do that? Would you have a good trial lawyer who knows what the odds are in those kinds of matters help make that decision, or just some doctor who works for the American Medical Association do it, or what?

Ms. WITTKIN. I think in large part you would need attorneys who have some qualifications in this area, perhaps with mediation or some other things. One of the—

Mr. BROOKS. We are getting mixed. Some of the doctors think they are lawyers and many of the lawyers talk like doctors.

You know how they are when they get into that mode.

Ms. WITTKIN. One of the things I might suggest is that we look at some other State models that have binding arbitration programs or alternatives to get a sense of what mixes are working best and what kinds of compositions would be the most effective.

Mr. BROOKS. Thank you.

Ms. WITTKIN. But another way to also, if I may, get more people into the system, that 98 percent that is currently locked out, would be to extend the statute of limitations for filing cases.

I can tell you that as someone who deals with victims every single day, that most people, particularly those who are seriously injured, have no idea that the statute in their State or in their county or city hospital may only be 90 days to file notice of filing a claim, or a year in certain States, or a year-and-a-half in other States, and I think that a lot of meritorious cases are locked out of the system definitely as a result of that, and I would also like to address something that Dr. Hannan said about the differences between the California and New York malpractice premium issues.

I have been working very diligently on these issues with regard to the obstetrical care crisis in New York State for several years now. One of the things that Dr. Hannan failed to mention is that unlike California, New York State already has a cap of sorts in place.

That cap is embodied in something called excess liability coverage or an excess liability pool. Every doctor who has privileges in a hospital in New York State must carry a certain amount of malpractice insurance, \$1 million per incident, \$3 million a year.

Over and above that, the excess liability pool, which is funded by fees paid by consumers covered by Blue Cross/Blue Shield, pays another \$1 million, \$3 million on top of that.

So doctors in New York State are already getting a great deal compared to what they would really have to pay out in these cases without excess liability coverage. And when you take into account that New York State already has in place mandatory periodic payments, which means that the value of a case is dramatically reduced, and that we also have the elimination of the collateral source rule, and caps on attorney's fees, you can't say that New York doesn't have what California has, and I think New York in

some instances provides an even better deal for malpractice doctors than California does.

The deputy commissioner of insurance in New York State met with the State senators and many doctors from the Medical Society of the State of New York several months ago to discuss this very issue, and what she said was simply that doctors in New York would not benefit by having a cap on noneconomic damages, and I can tell you from a public policy perspective just looking at what tort reform does in general, the American people will not benefit from a cap either.

Mr. BROOKS. Mr. Corboy, you had a comment. The gentleman is recognized.

Mr. CORBOY. Yes, sir, thank you.

The use of arbitration subsequent to filing a lawsuit, it can't be—

Mr. BROOKS. Is that microphone on? Pardon me, sir.

Mr. CORBOY. I am sorry. Excuse me. I apologize. Wayne County, MI, has mandatory arbitration in all cases. I am familiar with it because I have advocated, although I am a trial lawyer and it may sound inconsistent, I have advocated before your legislature.

We have been turned down by our legislature, I have advocated ADR in all cases, not \$50 cases, not \$500,000 cases, all cases. Wayne County, MI, which is Detroit, has the same type of litigation medical malpractice climate as does Cook County, IL. Wayne County is Detroit, it is a large community.

The difference is that in Wayne County it takes a year-and-a-half to dispose of litigation. In Cook County, it takes 3½ years. The reason being, according to the lawyers in Detroit, that they have two things in Michigan and that portion of Michigan which most States do not have. They have prejudgment interest, which is one way of keeping cases from going to judgment, and they also have mandatory arbitration, nonbinding, and with that as a basis, the litigation that has to go to trial is defined and determined earlier and cases get to suit earlier, and we in the ABA would have absolutely no objection to mandatory arbitration as long as it is not binding or the parties argue to binding arbitration.

Obviously you can't do away with the right to trial by a jury, so there has got to be an agreement by the parties to have binding ADR. If the parties want to do that, not as a condition precedent to being treated by a doctor or to get the health care providing from any medical care provider, but after a relationship is created, as long as the parties know it is mandatory, the ABA has no objection to it.

Mr. BROOKS. That is interesting.

Mr. Keener, did you want to comment?

Mr. KEENER. Yes, Mr. Chairman. My office and my partners have, over the years, literally tried hundreds of medical malpractice cases. We have also arbitrated many.

I cited earlier a overall success rate of 80 percent for malpractice defense cases. My firm has been lucky enough that in trying medical malpractice cases, we have won in excess of 90 percent of those cases.

Mr. BROOKS. Which side have you been on?

Mr. KEENER. The defense side. We have won in excess of 90 percent of the jury trials. We have a great deal of faith in jury trials. We never ever ask for a court trial, because we have a lot of faith in the American public.

We have also tried many, many arbitrations in which the parties have contracted—it has not been compelled on them, but they have contracted—or doctors have contracted with their patients, and that success rate drops down to about 65 percent.

So what I recommend to my physician clients is don't arbitrate. Go in front of a jury. Nine times out of ten, we are going to win that case.

And arbitration is not cheap. People talk about how quick it is and how inexpensive it is. That is not our experience. So I firmly believe that the American people should have the right to civil jury trials, and I think our physicians are better off with a jury trial.

Mr. BROOKS. Now, how would you expect health care providers and consumers to alter their behavior in the event that the collateral source rule was eliminated? What do you think about that?

Mr. CORBOY. I cannot imagine any defendant, whether he be an airline pilot, a cab driver, a housewife or a doctor changing his or her behavior because of the collateral source rule.

All the collateral source rule does is shift expenses from one insurance company to another. I can't imagine a housewife being more careful for the benefit of the mailman if she knows there is a collateral source rule. I can't imagine an airline pilot being more careful for his passengers or her passengers because he knows there is a collateral source rule.

I would like to think—and I do think—that the doctors of America are honorable people and their behavior is not going to be any less or any more careful just because of a collateral source rule. I can't imagine their behavior being any different.

Mr. BROOKS. You don't think that it would make people who bought insurance recover less than those who did not?

Mr. CORBOY. Oh, yes, sir, yes. That may happen. There may be an elimination of damages to the individual person, yes, sir.

Mr. BROOKS. Prudent—

Mr. CORBOY. Yes, sir, and they may have contractual rights. They have sat down at the table with management, as a result of labor and management agreements, that may be a nullity if the collateral source rule is done away with.

But I don't believe that the collateral source rule would affect the performance of doctors any more than any other potential tortfeasor.

Mr. BROOKS. Mr. Keener.

Mr. KEENER. Mr. Chairman, I don't think that the collateral source rule is an issue. If you do away with it, as we have in California, where in medical malpractice we can bring out the fact that the patient has health insurance—of course they cannot bring out the fact the defendant has malpractice insurance. But if that is brought out, and if the health care provider, that is the insurance carrier, wants to file a lien on that case, they get that money. So the defendant is going to have to pay the money.

It is just not going to the victim; it is going to another insurance company.

Mr. BERMAN. Would the Chairman yield for one question?

Mr. BROOKS. Mr. Berman.

Mr. BERMAN. But where there was no subrogation, there can be no doubt that allowing the evidence that the plaintiff has been paid for his medical damages would reduce the amount of the recovery and prevent the plaintiff from recovering twice for the same medical damages, right?

Mr. KEENER. That is right, where there is no subrogation or no lien.

Mr. BERMAN. Where there is no subrogation or no lien, if you can't introduce evidence of collateral sources, then it is possible the plaintiff, who is supposed to be made whole from this action, will actually recover twice from his health insurer and from the malpractice insurer for the medical damages; isn't that correct?

Mr. KEENER. What we are seeing is more and more health care coming in, but you are correct.

Mr. BERMAN. Thank you.

Mr. BROOKS. You agree, Mr. Corboy?

Mr. CORBOY. No, sir, I don't. He is not recovering twice. He is recovering once. His insurance company is getting paid, so he is not getting paid. His insurance company is getting paid. He is getting paid once for the medical expenses.

Mr. BERMAN. Will the chairman yield just to followup?

Mr. CORBOY. Pardon, sir?

Mr. BERMAN. Evidence comes in about medical damages, medical expenses already paid, hospital expenses, doctor's bill, future medical damages. He has already been paid that by his health insurance provider.

Mr. CORBOY. Which he gives back. He pays for it. He gives—

Mr. BERMAN. Not unless there is a subrogation. Acknowledge the fact—I understand your point, you made it in your testimony, if there is subrogation, he gives it back. If there is no subrogation, he recovers twice, doesn't he?

Mr. CORBOY. He recovers once. He doesn't recover at all if he doesn't get paid. Let's assume I have got a bill for \$10 and my insurance company pays the \$10, I am not getting it. The doctor is getting it.

So I am not getting paid twice. I am going to get paid once for that \$10.

Mr. BERMAN. And then when you present the evidence that you had medical bills for \$10, your award includes that \$10.

Mr. CORBOY. Yes, sir. I am only saying he gets it once. The doctor gets it the first time.

Mr. BERMAN. Come on. He is getting \$10 more than he would need to get to be made whole.

Mr. CORBOY. Yes, sir, you are absolutely correct. But in the meantime, he may have been paying a dollar a year and he has never collected on it, and now he collects that dollar in \$10 payments later.

Ms. WITTKIN. May I just make a brief comment?

Mr. BROOKS. Ms. Wittkin.

Ms. WITTKIN. I think that a good solution to this is to have the kind of collateral source rule in our Federal health care reform that California does, where, information about collateral sources can be

introduced as evidence, but that there would be a right to subrogation and that would take care of that problem.

But if you just eliminate the collateral source rule so that victims' awards are automatically reduced by that amount, what you are doing is forcing the taxpayers and employers to pay all of that that the liable party, or wrongdoer, should have been responsible for, and I don't think that that is fair. And I think that many people in this country don't think it is fair either. It doesn't really serve anybody to do it that way. Also, when you eliminate the collateral source rule, as interpreted in the Clinton bill, which eliminates past, present, or possible future collateral source benefits, it is particularly cruel.

How do I know today, standing before a jury, that in 10 years from now, I will be eligible for this disability program or that social service program, even though my award would automatically be reduced by that amount? What if I am ultimately not eligible? What if that program has gone bankrupt? I can't go back to the court system and ask for money to pay for those services out of pocket.

So I think that it is very, very unfair. I don't, however, think it is unfair, to reimburse health insurers or others for money they have paid out caring for these people who have been injured by incompetent or negligent practitioners.

Mr. BROOKS. Thank you. I have one more question. To what extent, if any, can recent increases in health care costs be attributed to medical malpractice claims?

Dr. Falcon.

Dr. FALCON. Yes, I would like to answer that question, but before I leave, I would like to just mention one thing.

Mr. BROOKS. Not the Harvard report again.

Dr. FALCON. No, sir, not the Harvard report. I think it is very important for this committee to know that doctors at the grassroot level are not upset about the malpractice situation because it exists or that we don't feel that there are bad doctors out there. We feel there are.

What really upsets us is that such a small percentage of the medical malpractice premium is going to where it should be going, and I would challenge the gentlemen here on this table to even go to the point where, why don't we reverse it, why don't we give two-thirds to the patient and let the bar keep one-third?

To me, that is a very important point. That is what upset doctors. If I injure a patient and I have \$200,000 worth of insurance, I would like for most of that money to go to my patient, and in fact what happens, it doesn't. And that is what is really upsetting.

Mr. BROOKS. Well, you understand the system that we now have in States: The defense lawyers make virtually as much money as the plaintiff's lawyers in defending the case, arguing it, and presenting the facts from the doctor's position, the insurance position, et cetera.

Dr. FALCON. Yes, sir, very clearly.

Mr. BROOKS. Do you want to eliminate them?

Dr. FALCON. I don't know, Mr. Chairman. But that is why we are saying that the system is broken, and when we have victims injured, more of the malpractice money needs to go to them.

Mr. BROOKS. All right.

Mr. Corboy.

Mr. CORBOY. Yes, sir, I think I can answer your question specifically, and I will supply them later with some documentation. I believe that the cost of medical malpractice premiums last year or the year before, whenever the latest figures are, are \$9 billion.

I believe the insurance companies collected \$9 billion. Out of that \$9 billion, they paid somewhere in the neighborhood of \$3 billion in payments.

Now, what happened to that \$6 billion differential, I can't answer, but I will give you the statistics that I just supplied you.

Now, out of that \$3 billion, attorney's fees are paid to both defense lawyers and plaintiffs' lawyers and administrative costs, and everything else out of that \$6 billion. The cost of running the insurance business comes out of the \$6 billion. So I don't know where the \$6 billion goes.

In your inquiries as to whether medical malpractice reform or deformation should be examined in toto, I suggest you also find out how much money the insurance companies are making.

The insurance company in Illinois, the doctor-supported insurance company, paid back money to their subscribers last year. The doctors paid premiums, yes, but they got money back, and I suggest to you that you find out what amount of the dollars that are actually collected are going into the profits of insurance companies and how much of those dollars are spent for administrative costs rather than for lawyers which comes out of the corpus of the payment.

Mr. BROOKS. Dr. Keller.

Dr. KELLER. Thank you. This is an interesting question, and the \$6 billion and \$9 billion is interesting. Of course, much of that \$6 billion is being held in reserves for potential claims.

I happen to be on the board of directors of a small physician-owned and directed insurance company in Maine, and it is a mutual company, so we are—we cannot make a profit. We have for 2 years returned small amounts of money to physicians because there were extra funds over reserves for potential claims.

For years of course, that didn't happen, and all of our indicators are showing that that trend is now reversing. The frequency of suits is going up and clearly the awards are going up, so that I don't think that we can attribute the amount of money going into the malpractice arena to insurance company profits since most companies are now physician owned.

I forget the exact percentage, but the majority of malpractice companies in this country are now physician owned because of the prior malpractice crises when the commercials pulled out. I don't think there is a lot of excess profit. I think a lot of those monies are used.

Ms. WITTKIN. Mr. Chairman, may I just add something?

Mr. BROOKS. Yes, ma'am.

Ms. WITTKIN. I agree with Dr. Falcon. I think that we definitely need to find a way to get more of the money to the victims or their families, and some of the things that our organization is suggesting, I think, will do that.

First of all, States like California have a statute of limitation on the disposition of cases, so once a case is filed, it must be disposed of in any way or another within 5 years.

We are recommending that there be a statute of limitation on the disposition of all cases within 3 years, plus special consideration for terminally ill patients and children in expediting the handling of those cases.

Right now, as you heard earlier, malpractice cases have tales of 7, 10, or 12 years in some States, and if you are looking at why so little money is going to victims, you have got to look at that as one of the leading culprits, because defense fees just keep piling up as the case drags on because defense attorneys get paid hourly win, lose, or draw.

I think the other thing we should take a look at is we are constantly talking about the need to reduce attorney's fees, but we are only talking about reducing plaintiff attorney fees, and I think it is time we talked about finding a fair solution and reduce defense attorneys fees as well. That will also filter more money back into the system for victims and their families.

The other thing is that there was a study done in New Jersey last year by the American College of Physicians based on a review of 15 years of malpractice insurance claims by one malpractice insurance company, and as I said earlier, this study found that 58 percent, close to 60 percent of all indefensible cases by malpracticing doctors were nonetheless won by those doctors and their attorneys at trial as opposed to 5 percent of defensible cases won at trial by plaintiffs.

That suggested to me that while it may definitely suit doctors to go to jury trial all the time; it certainly is not in the best interest of patients. When we talk about frivolous lawsuits in this country, why aren't we outraged that almost 60 percent of cases that doctors should be losing, they are winning at jury trial. There should be some sort of punitive action or penalty attached to that practice to eliminate that kind of abuse.

Also, I think if you outlaw or prohibit doctors and hospitals from entering into secrecy agreements as a requirement of settlement, you will move cases along much more quickly. Right now, victims are being held hostage by these agreements. They are pushed to the wall. It doesn't matter if it takes victims 2 years to fold or 3 years to fold, the defense can afford to wait.

It is in the interest of the doctor and the hospital to keep many of those agreements secret and they do it. They don't settle the cases until the end, until the family says, I have this child, he or she has got all these medical needs, what am I going to do, I have to settle, and I have to go along with the secrecy agreement which means nobody will ever know about what this doctor or this sub-standard hospital did to my child and my family and myself.

I think all of these things are definitely viable alternatives and solutions to the system and will help bring more money to the plaintiff. That coupled with mandatory binding arbitration at plaintiff's request for cases under \$100,000 will definitely bring much more money to the plaintiff.

Mr. BROOKS. Mr. Fish, the gentleman from New York.

Mr. FISH. Thank you, Mr. Chairman.

Mr. Keener, I would like to get into the question of enterprise liability. You did not specifically address the provision in the President's bill regarding enterprise liability, as you may know, the provision would substitute the physician with the health care enterprise should the physician be sued for malpractice.

And my question is: Does your organization have an opinion on that proposal and if so, would you comment on it?

Mr. KEENER. Congressman, that is one of the few aspects of the proposal that we have not as yet taken a position on.

Mr. FISH. OK. Would you let us know what and when you do?

Mr. KEENER. Absolutely.

Mr. FISH. We are not sure how long the Congress will be at this. Could be a while.

Dr. Keller, in your Physicians Payment Review Commission Report, you stated that you conducted an extensive analysis of the medical malpractice problems prior to making its recommendations for reform in the 1994 annual report to Congress. Could you tell us more about just what research was conducted and more about the analysis? On what evidence was the commission's recommendation on malpractice reform based?

Dr. KELLER. The commission had its own hearings on this issue and had expert testimony from a number of sources across the country. We have on our staff a physician/attorney who is an expert in these fields and has done a great deal of his own research on various aspects of the malpractice issue. In addition, for this annual report, 1994, the commission underwrote a study by some of the researchers in the same Harvard group that has been referenced in terms of the famous New York report who looked at several aspects of the malpractice issue, particularly the guidelines issue. They focused on whether guidelines were going to be helpful in this whole arena of trying to better define what is a compensable injury and how better to handle it.

That study showed that the guidelines are not being very much used at this point, only about 7 percent of cases reported. An analysis of files that involved guidelines showed that where they were used, they seemed to offer some optimism for controlling, as you will, the number of cases.

In other words, where there is a useful guideline, cases may not be brought or cases may be settled. So it has been that combination of our own internal research, testimony, and our own commissioner's analysis that has resulted in the recommendations that we presented to you.

Mr. FISH. With regard to your support for practice guidelines, is it your opinion that such guidelines, when used to defend doctors should constitute an absolute defense or merely an affirmative defense? Furthermore, if such guidelines are used by plaintiffs to bring suit against doctors, should they be able to be used to establish a prima facie case?

Dr. KELLER. I can't answer that question very well. Our opinion on guidelines is that we don't have the final answer yet. The experiment in Maine uses guidelines as an affirmative defense, that is, in the demonstration under the law physicians may use the guidelines, but plaintiffs can't.

So the physician can say, I followed this guideline, I took care of the patient according to the guideline. There was an adverse result, but this case should be dismissed on the basis of following the guideline. The trial bar in Maine is absolutely convinced that that is not constitutional, and the first chance they get, they will obviously bring it to the State Supreme Court and test that theory. We have had views on both sides of that particular question.

Our experiment with guidelines in Maine is still ongoing. We don't have a lot of information to report yet, but we think there may be a useful role for them. And clearly if guidelines are available and are useful, one would anticipate that both sides would inevitably wish to use them, and I have no personal objection to that.

If there are acceptable standards of care, everyone ought to be able to access that information.

Mr. FISH. Dr. Hannan, I am going back to this cap on non-economic issue, which you developed and which you were questioned about. I think you stated that this is the only major component of reform which differentiates New York reforms of the mid-1980's and the California Landmark Reform Act, MICRA, and you argue that this lack of a cap in the New York reform law is what has made it less effective than the California effort. Can you explain to us in more detail how the cap might be effective in New York based on the success of the reform in California?

Dr. HANNAN. I think it is clear that the trend in judgments is increasing and the—it is in the noneconomic damages for alleged pain and suffering that we are seeing the greatest increase in the awarded judgments.

If there were a cap in New York like there is in California limiting this award to \$250,000 per case, we probably would not see the kind of judgment that came out of one of our downstate court-houses recently where an award of \$90 million was made.

I just don't think you could reach that kind of a judgment without noneconomic damages playing a major role in that.

Mr. FISH. Thank you. In your view, are there particular medical specialists that are disproportionately victims of the medical malpractice system as it currently operates? And if so, why?

Dr. HANNAN. Well, there are certain specialties that have higher premium rates because the experience rating of those specialties shows that they are more likely to be sued.

Whether they are victimized or not, I don't think I am in a position to make that statement, but clearly neurosurgery and obstetrics and orthopedics are three of the so-called high-risk specialties with higher premium rates.

Just elaborating on one point, for obstetricians, the case of the neurologically impaired infant is one which has gotten a lot of press recently, and in my opinion, needs to be removed from the tort system because medical evidence now shows that the vast majority of neurologically impaired infants have that disability not as a result of medical malpractice.

Mr. FISH. Dr. Hannan, in what State are medical malpractice premiums the highest? Is New York State one of the highest? It is my understanding that for an OB-GYN practitioner in New York State, the annual malpractice insurance premium exceeds \$100,000 per year, is that correct?

Dr. HANNAN. That is correct, and that is an average. As I stated in my testimony, downstate in the metropolitan New York City area, the cost is now going to be \$125,000 per year. In rural upstate New York where I practice, the obstetrical premium is \$45,000 per year.

I understand in Florida, the cost may exceed that in the range of \$152,000 in certain areas, but I don't have the specific details regarding the geographical areas of Florida that that has effect.

Mr. FISH. Could you answer my question about what States have the highest premiums?

Dr. HANNAN. It is my understanding that New York is one of the highest. I think Florida also carries a high malpractice premium that may exceed New York's rate.

Mr. FISH. Who sells medical malpractice insurance in our country? Are there many private carriers that offer such coverage? Does that constitute most of the malpractice insurance or is it true that it is sold in our country through not-for-profit companies established by medical societies?

Dr. HANNAN. Well, in New York State there are four insurance companies that are certified by the Superintendent of Insurance to sell malpractice coverage, and in order to have hospital privileges, a physician would need to be insured by one of those companies.

There are so-called offshore or out-of-State carriers who can provide malpractice insurance for those physicians who are not on hospital staffs, but in general, the vast majority of physicians practice on hospital staffs and would be insured by one of the four carriers, and these are not for-profit insurance companies, mutual companies, as was previously alluded to.

Mr. FISH. Thank you very much.

Thank you, Mr. Chairman.

Mr. BROOKS. Mr. Conyers.

Mr. CONYERS. Thank you, Mr. Chairman, and my congratulations to you on holding this hearing because this is one of the collateral issues to health care that is very important that we view along with the development of health care reform as it is moving along.

I would like to ask Ms. Wittkin about her impressions of the medical malpractice provisions in the Clinton bill, H.R. 3600, if you have had a chance to look at them.

Ms. WITTKIN. Yes, as I said earlier, all of these provisions are anticonsumer and regressive. They are reforms that will do nothing to lower health care spending in this country, will do nothing to increase access to care for underserved populations. The only thing it is going to do is make the practice of malpractice more affordable for doctors who commit it. And what is most irresponsible about what we are seeing in this bill labeled health care reform is that we are only looking at the liability end of malpractice, like, how do you divvy up the money once the victim has already been harmed.

Why aren't we in this country looking at ways to prevent malpractice? Our organization looks at State medical boards all over the country, and dangerous doctors do have licenses to kill. State medical boards do virtually nothing to discipline or oversee the profession.

Last year fewer than 3,000 doctors were disciplined, and maybe 10 percent of those were disciplined for negligence or incompetence, and most of those doctors never stopped practicing and in this country. Doctors can easily move from State to State. They can lose a license in one State and go to another State and become licensed or oftentimes they can carry licenses in five or six States at a time.

Currently, we speak 50 different languages when it comes to State medical boards because there is no continuity or uniformity. We must do something to make them more responsive, more aggressive, and allow them to fulfill their mandates.

Mr. CONYERS. Do your recommendations include a Federal list of minimum standards that would be applicable to all the boards in the several States?

Ms. WITTKIN. Yes, they do, and what we attempted to do is look at every State medical board's regulations and statutes and pull out the best that we found in each State program and sort of make the new floor the old ceiling, and as a result, we think that it definitely goes a long way to give the States what they have not had up to this point.

State medical boards have been ignored by State legislatures. They have been underfunded, understaffed. They have been run largely by the medical profession, and I think that what we have seen for decades in this country is they have failed to do their job.

It doesn't matter if we stand on our heads and beg doctors, and we have, to take responsibility for their own profession. They fail to do it, and I think it is time that the American people got involved protecting the quality of their own health care, and I think that it is time that Congress support that.

Mr. CONYERS. Could you tell me just briefly how your recommendation list was put together because it is quite impressive and pretty comprehensive.

Ms. WITTKIN. Well, essentially, I have been looking at the malpractice question since my malpractice occurred over 13 years ago, and in doing research and working with a variety of other consumer groups that are involved and interested in this issue, what we have done is looked at the malpractice issue without our heads in the sand.

If there are legitimate gripes about the system not being fair to one side or the other, we want to know about them because we want the best system possible. What we are seeing, however, is a system so far tilted in one direction that we can't even get on level playing ground to talk about how to move that system and improve that system.

But the recommendations that we made reflect the joint efforts of a variety of citizen groups out there, public citizen, citizen action and so on, who have looked at the issue, looked at tort reform, looked at the effects of tort reform, studied research, read every report that was done on it, and what we have come up with, we think, places us on the road to a solution to this crisis.

Mr. CONYERS. Thank you very much.

Mr. Corboy, do I understand that arbitration is your major recommendation to this committee in terms of dealing with the problem?

Mr. CORBOY. No, sir. I have some negative recommendations, but we have gone through those. No. What I am saying is that the American Bar Association is in favor of some type of ADR in all types of tort litigation.

There is no reason why ADR should not be applied in automobile accidents, in product liability cases, in railroad accidents. Malpractice is just another, and I realize—I am not being derogatory of the genre, but malpractice is just another type of tort, and it should not be singled out and given any type of specific differentiation in the litigation process.

We are in favor of all types of torts being arbitrated or mediated or doing something so that the cases that have to be tried. This amount is a small number. In every urban community in the country, less than 5 percent of the cases go to verdict. That is true in Detroit, MI. It is the same in Chicago. It is in New York, also.

No matter what system we have, 4 to 5 percent go to verdict. Therefore, if you can delineate and isolate those 90 percent of the cases that never reach the litigation system by way of settlement or verdict, I say 90, and I realize the differential of 5 or 6 percent.

Those other 5 or 6 are abandoned or they are kicked out of court because of summary judgments, but let's assume that 85 to 90 percent go out of the system by way of settlement. One way to isolate those cases is to have some type of ADR as a condition precedent to going to trial, but not as a condition precedent to filing a lawsuit.

Mr. CONYERS. Have you found that caps are sometimes an easy way to try to solve a very difficult problem? I mean, economic caps, it seems to me, would in some ways hurt patients a couple of times.

Mr. CORBOY. Absolutely, sir. You know, it is very easy to reduce a premium. If I were in the insurance business and I set about to issue an insurance policy wherein only Congressmen or Congresspersons would be eligible to buy the premium and they had to be killed on the quarter of 42nd and Broadway in the middle of the afternoon in the summer months, you can appreciate how small the premium would be.

You could buy that policy for practically nothing and get a \$10 million compensation if you fit the system, if you fit the contingency.

Obviously, if you take out of the potential for a medical malpractice or any tort award, if you take out of that potential compensation for payments for noneconomic damages, we will take the housewife, we will take the child, we will take the elderly person, where the medical damages and medical expenses have been determined, there is no future medical expenses for the blind housewife, it is very easy for that case to have a lesser premium than the case where compensation is going to be awarded as we know it today.

So putting a cap on any type of recovery for the victims of a tort, whether it be automobile, airplane, railroad, or anything else, obviously is going to have the potential for reducing premiums. Whether they do reduce the premiums is within the confines of the carrier, but at least it has the premium.

If they are going to have to pay out less, the potential for the premium is less. However, but the only person that can be hurt—certainly the insurance company can't be hurt by paying out less.

The only person that can be hurt is the seriously injured person. The most notoriously injured person is the one that would suffer the most.

Mr. CONYERS. The more severe the injury, the more limitation that would occur as a result of caps?

Mr. CORBOY. Yes, exactly.

Mr. CONYERS. Could I ask Ms. Wittkin what her case against caps in summary would be? And then I would yield to any other doctors that are—and lawyers that would want to respond.

Ms. WITTKIN. Well, I think that you sort of just said what I would say, as well, and that is that for people who are the most seriously injured in our society and people who are poor and elderly, who don't have the compensable economic losses, who don't have compensable medical expenses, will be devastated by caps. And if you couple caps with the elimination of the collateral source rule the only compensable area left for the poor's elderly is pain and suffering. And capping that would prevent more of these victims from seeking legal redress.

I think it is outrageous in this country that we would arbitrarily and capriciously limit damages when we do nothing to stop dangerous doctors—do you know that we have doctors in the New York State with dozens, if not hundreds, of malpractice cases against them? We can show you case after case after case of doctors who have moved across this country over the last several years killing people, getting relicensed, getting insurance or not carrying any insurance, and going about their business.

Why would we want to further harm those people who are already our most vulnerable members of society? It is cruel, it is inhuman, and the reality is that we should be looking at prevention, and the reality is also that these tort reforms, particularly MICRA with its cap, have not demonstrated in any way a reduction in health care spending in the State of California, have not demonstrated in any way increased access to underserved areas, and those were two of the biggest selling points of MICRA.

The only thing MICRA has done is put money in the pockets of doctors because premiums have gone down, and I think it is a disgrace.

Mr. CONYERS. Thank you.

Mr. Keener and Dr. Falcon.

Mr. KEENER. Congressman, with reference to caps, I think the ultimate issue that we must all focus on ultimately in our justice system in this country is fairness. Is it fair?

If you look at MICRA, which was enacted in 1975, a cap of \$250,000 was imposed. That \$250,000 is still in place today. That, I understand, is the number that is in H.R. 3600.

I had an economist run those numbers yesterday for me. That \$250,000 is now worth \$84,011.

Mr. BROOKS. I figured that in my head a minute ago. That is the interest yield on it. The other alternative, the more conservative alternative, would be to make an annuity out of it. Then one would have to look at the plaintiff's lifespan. If the annuity projected the plaintiff would die at 66, then the payout would be \$15,000 a year until age 66; if the plaintiff didn't die at 66, the annuity would cease.

Mr. KEENER. What we actually did, Congressman, was two things. One, we took the Consumer Price Index. That got us down to \$84,011. We also took triple A bonds, and that value would be \$46,000 or \$48,000, so there has been an enormous drop since 1975 in what \$250,000 is worth.

And I commented earlier about unfairness to certain parts of our population.

Mr. CONYERS. But there would be an argument against it anyway, even if we had—suppose there was an adjustable provision in there so that the cost of living would be factored in. Would your argument disappear then?

Mr. KEENER. It is the same. In fact, if I may, let me give you a quick example of a gentleman that went to trial against a doctor we represented in the early 1980's. He was a man in his early 60's. He was at the end of his working career. He came in to have a cancerous kidney removed.

There was a mistake in the OR. They switched the x-ray, and removed the healthy kidney. Then he had to go back later and have the cancerous kidney removed. That man has lived to this day on dialysis every day. His total recovery was \$250,000 because he had no loss of earnings since he was retired.

That, I submit, is not fair. The jury actually returned a verdict of just over \$2 million, but that was cut by MICRA to \$250,000.

Mr. CONYERS. Thank you very much.

Dr. Falcon.

Dr. FALCON. Thank you, Mr. Congressman. I would like to mention one thing that Ms. Wittkin has mentioned that has not been touched on, and that is quality.

We cannot have any changes in health care without assuring our patients that quality will remain in place, and I would just like to touch on a few issues to tell you what our problems are in dealing with quality and physicians that do have a problem.

There are several things in place right now that help to insure quality for patients. We have hospital medical staffs at the local level that do utilization and quality assurance review. It becomes a real problem, though, when you try to get rid of a bad doctor, because it goes to the courts automatically.

Sometimes the doctors that do things in OR are afraid they are going to turn around and be sued, so that is something at the Federal level that could be done to try to help doctors in policing their own at the local level.

We have insurance carriers who do utilization review, so when I admit a patient with pneumonia, I have to call the insurance carrier and justify that that patient has pneumonia and needs hospitalization. We have the Board of Medical Examiners. I agree that for a very—in Texas about 2,300 doctors are sanctioned a year by the BME, but there is another bunch that is sanctioned by the PRO, and that is a system that I think is very effective as a watchdog over quality of care.

We have a tort law system which probably is the least effective and the most costly in having a sentinel effect on medical malpractice. I do not know of a single doctor who has been sanctioned as a result of a medical malpractice case, and we have laws in

Texas that force the BME to look at doctors who have had several medical malpractice cases.

Mr. CONYERS. So you support some of the recommendations of the Center for Patients' Rights that would create more severe sanctions and more effective review of doctors who practice poorly?

Dr. FALCON. Yes, sir, but I think it is also real important, and we have noticed this in Texas, quality does not equal medical malpractice, and it is really unfortunate because that is a misunderstanding that a lot of people have.

We do not have the same doctors that are sanctioned for quality reasons that are sanctioned—that come up as a result of medical malpractice. Two-thirds of our neurosurgeons get sued in Texas just about every year, and that does not mean that two-thirds of our neurosurgeons have quality problems.

I would like to add just one thing. The data bank. The Federal Government could turn the data bank into a very constructive system. If we are collecting data all over this country on what is causing malpractice, why not use that information to educate the medical public about what is being done wrong and what can be done to improve it?

Mr. CONYERS. Well, why not use it in the way that they propose to use it as well?

Dr. FALCON. I am sorry, which was?

Mr. CONYERS. Well, under—I thought that was a pretty good idea making the data bank more available for people to understand who is doing the wrong thing where.

Dr. FALCON. Well, I mean, that is an option that you have, but let's carry it a step forward. If we recognize—last year in Texas with our PRO, we recognized that there was a problem with putting nasal gastric tubes into patients.

There were three cases that we picked up where the tube was put into the wrong place, and two resulted in patients' deaths. Immediately we notified the practitioners of the State of Texas that the standard of care had to include a chest x-ray to make sure that there was proper placement.

We took the initiative to educate physicians and say, this is a problem and this needs to be changed. I would like to see that done with data bank information also.

Mr. CONYERS. Dr. Keller.

Dr. KELLER. Thank you, sir. In another part of the commission's report, we talk about model practice acts and that may get to some of the issues of standardization of standards for physicians across the country and the objections, with which I agree, regarding 50 State boards of licensure with standards that are very uneven.

They are clearly, at least the ones I know about, underfunded. They can't do the job they want to do. We should also consider the fact that there are lots of other people who provide health care other than physicians, although physicians are certainly on the forefront, certainly on the forefront of litigation. But there will be more and other kinds of providers who will be also subject to litigation in the future, such as nurse practitioners, certified nurse specialists, physician assistants, and the like.

So we have advocated the development of some model practice acts on the Federal level that might indeed help to address some

of these issues. I think we need to reform the whole system and we advocate this in our report. We don't believe that the current tort system is at all efficient or effective, and continuing to support that in a major way probably isn't going to help very much.

So we have advocated in our report, as I indicated, some fairly major long-term restructuring of the system which ought to make it better. Not simple to do, can't be done overnight, lots of research and demonstrations need to be done to produce that.

That is probably the best answer. We think more patients ought to be covered than are at the moment. The current system isn't going to do it that well because doctors are forced to try to defend themselves, even in instances where they may not wish to, as has been suggested.

We also make a different recommendation about caps that I think is important. We don't agree with a single cap at this point, \$250,000 or whatever amount. We have advocated a schedule of caps, recognizing that there are some injuries and events that are much worse than others, and in which case a higher cap for non-economic damages might be very appropriate. There are some where that is clearly not true and a lower cap would be appropriate.

Again, we need to do research and develop some demonstrations to decide what those levels of caps or specific schedules might be.

As an interim one to try to get control over this very expensive component of the system, and I agree that it is, a single cap might be put in place, but we don't think it ought to stay there. We think we ought to work towards these schedules. And a very important element in all of this is the need for more information, and I don't think this has been emphasized enough.

We certainly do in our report. We need a lot more information about malpractice events, and negligent care than we currently have. That requires new data systems which in fact would help the entire health care system. We just don't know a lot about these kinds of events, and we don't have large data bases to several trends and profiles which allow people to see where the problems are. I think it is a very important component.

Mr. CONYERS. Thank you very much.

Thank you, Mr. Chairman.

Mr. BROOKS. Mr. Gallegly.

Mr. GALLEGLY. Thank you, Mr. Chairman. This has been a most interesting hearing this morning. I think we have really had an opportunity to hear some excellent testimony.

On this issue of caps, and I think Mr. Keener had a good example a few minutes ago about the retired individual who didn't have any real financial or economic damage, let me ask you this: Do you believe that there should be any type of caps or a schedule cap on pain and suffering? Do you think it should be completely open-ended? I think Dr. Hannan pointed out a case in New York where there was a \$90 million judgment for pain and suffering. Is that easy to justify?

Mr. KEENER. I would have to look at that verdict to understand it. I can first answer your question. I do not believe we should have caps. Let me also say that from our own experience in having tried hundreds of medical malpractice cases, we have only had two ver-

dicts come in in excess of \$1 million. One was for \$22 million in a case where the physician showed up under the influence of cocaine, delivered a baby and separated—essentially separated her head from her spine so she can now move only from the neck up. That case was settled for \$3 million. The other million dollar case was a case where there was billing fraud, and it didn't have anything really to do with malpractice at all.

So you hear about excessive damages, but we actually, in trying these lawsuits, and believe me, we try them a lot, we don't see them. Every once in a while you will have a runaway verdict, but that is why you have the person in the black robe. It is his or her responsibility to cut that verdict, and they do that.

Mr. GALLEGLY. Dr. Falcon, let me stray for a second here, you brought up a subject that is of great concern for me as a Californian—the issue of providing health care services to undocumented aliens, and you mentioned that in your community this is a concern.

In the city of Los Angeles, where I am from, in the last 3 years, over two-thirds of all the births in the county-operated hospitals, the mother had no legal right to be in the United States.

Do you have any idea of the approximate percentage of patients that your group treats that have no legal right to be in the country?

Dr. FALCON. Yes, sir, I would think that our particular experience is about 35 percent. In the urban areas, San Antonio and Houston, I think it is a little bit lower than that, but it is still a significant part of the practice.

We used to be able to deliver—or had to deliver those patients under Federal mandates without compensation, and it was causing a lot of problems with providers and practitioners, and that is why I think it is very critical that if there is no language or no provision for illegals, that those mandates be removed, and that somehow or other we be allowed to let those patients know that it is going to cost them if they want health care delivered in this country.

Mr. GALLEGLY. With those mandates, have you actually found that doctors have moved to higher ground or left the area because of the economic effect it has had on their practice?

Dr. FALCON. No, sir. In our area we did it. We are the only group in town, there are seven doctors in my group, two nurse practitioners and two physician assistants, and we—there is no way we could turn those patients down because they could have no care otherwise.

Mr. GALLEGLY. I didn't mean turn them down. But just because of the economic effect it is having, when I say move to higher ground, I mean maybe move to Amarillo or someplace else to practice medicine.

Dr. FALCON. No, sir. We like the heat, just like you had it yesterday. The one thing that did hurt, though, was that we were delivering those babies and exposing ourselves to potential lawsuits without any kind of remuneration for our services.

Mr. GALLEGLY. That brings up another question. To your knowledge, have there been actual lawsuits filed for malpractice by those who were seeking services in this country that had no legal right to be here?

Dr. FALCON. I think every single one that has been filed in our community, but one has been from patients from across the border.

Mr. GALLEGLY. You are saying that every malpractice lawsuit that you are aware of, and that accounts—let's back up a second. About a third of your patients are illegal immigrants, yet 100 percent of all the lawsuits that have been filed have been filed by illegals rather than citizens?

Dr. FALCON. Not 100 percent, but very close to it.

Mr. BERMAN. Will the gentleman yield?

Mr. GALLEGLY. So, the likelihood of having a case filed against you for malpractice is greater on a per capita basis by someone who is here illegally than a citizen of this country?

Dr. FALCON. Absolutely. Because what happens, most of those patients are walk-ins. The one that I can remember that was just filed recently is a patient that spent 7 days seeing doctors in Mexico, had a ruptured appendix, developed a huge abscess, came into our community septic, almost dead, was resuscitated, had surgery, had to have a permanent colostomy, and is suing us because he has a colostomy.

If this fellow hadn't gotten to our hospital within a few hours, he would have been dead. But that is the kind of gratitude that some of those patients have.

Mr. BERMAN. Will the gentleman yield?

Mr. GALLEGLY. Certainly.

Mr. BERMAN. So from that, I gather it would be safe to conclude, at least in southern Texas, if you could get rid of malpractice cases by undocumented people, you would not have a malpractice problem?

Dr. FALCON. We would have a much smaller problem, yes, sir.

Mr. BERMAN. Well, you talked about a hell of a lot of reforms when the whole problem, according to you, or a big part of it is coming from people coming across the border.

Mr. GALLEGLY. I thank the gentleman and I want to thank all the witnesses this morning.

Thank you, Mr. Chairman.

Mr. BROOKS. Thank you.

Mr. Berman.

Mr. BERMAN. Mr. Chairman, thank you.

I want to echo my colleague from California's comments and thank you for holding this hearing. It has been very interesting.

I had the misfortune to chair the Select Committee on Medical Malpractice in 1975 when Travelers Insurance decided to raise the premiums on, I think it was Ob/Gyn's by 476 percent, thereby precipitating a physician strike and then a major effort to change the tort laws as well as to look at alternative ways of dealing with medical malpractice insurance coverage.

While I supported a certain number of the changes in the law at that time, I have to say that the legislation that went through got away from me, to say the least, and was far more sweeping, and I think in some way injurious, than is appropriate.

But I find the whole thing very, very funny in a way. Because on the one hand, I have never seen a report which would indicate that the health care inflation index in California since 1975 in terms of costs of health care for consumers is substantially lower

as a result of those sweeping, sweeping reforms that we undertook and which the physicians of this country are asking us to now federalize in effect. You may talk about premiums not having gone up much, but no one makes any case that health care costs in California are significantly lower than they would have been without those reforms, or significantly lower than anywhere else in the country. If anything, the very, very recent deescalation of inflation in California may be prompted by the fact that it is leading the way in the area of managed care and leverage by different kinds of health maintenance organizations on hospitals and physicians and other health care service providers.

So I would love to see hands out to come to the Congress to say that this is at the heart of cost containment, it is not about medical malpractice insurance, given the lack of evidence of that in California over 20 years; we are not talking about a couple of years here. I find that to be very misleading, I think unintentionally, but misleading.

On the other hand, for those who talk about medical malpractice as the key way of deterring bad doctoring, I have seen no evidence that doctoring in California is significantly worse because recoveries are so tightly capped, attorneys' fees are so harshly restricted, the rules of evidence and the mandatory arbitration provisions are so onerous, and that therefore physicians practicing in California are worse, more careless, more negligent, more reckless than they are in other States.

Basically I think what you've got here is a tort system which, in the end, is designed to try to compensate the injured plaintiff for the negligent acts of a provider and to try to make the person whole.

It is not a great system for deterring negligence, and it is not the key to reducing health care costs, and so I think there is a hyperbole on both sides.

What I am interested in, though, is, from any physician who would like to comment on it, in California at the time, the whole thing was premised on this sort of tripartite deal. Doctors in health care, hospitals, are all going to get a break, a massive change in the tort law: These very harsh caps, which, as somebody has pointed out, have not been changed by inflation and now are massively discounted from what they were in 1975, very tight restrictions on attorneys' fees which prompt and promote certain kinds of settlements because the attorney's incentive to pursue the case to conclusion is vastly diminished, and other changes.

But the quid pro quo is going to be a meaningful and effective disciplinary system that is not going to depend on malpractice insurance to screen out substandard physicians, but is going to strengthen the system, and thirdly, we are going to deal with the insurance industry's windfall profits and their whole situation. But now, all of a sudden, we have sprung loose the one aspect of malpractice reform or tort reform from the other two reforms.

It would be another story if the physicians of this country came to Congress and said, give us tort reform and federalize and toughen up the discipline on doctors, and provide alternative mechanisms for licensing and—either in terms of federalizing it or setting standards that all States would have to comply with, have a major-

ity of public members, nonphysician members on the boards of these medical boards that regulate physician practices, and take over regulation of the insurance industry as well.

If the chairman's McCarran-Ferguson bill passes, maybe we will have a start of that, but I have never heard anybody talking about that side of the federalization. I would like to know, first from the doctors, if you would support a significant federalizing of disciplinary procedures for physicians at the same time that we now suck up from every one of the 50 States their ability to regulate tort law and federalize it in the area of medical malpractice?

Dr. FALCON. Mr. Berman, that system is already in place with your PRO's. The PRO's are charged with reviewing quality of care for medicare providers.

Mr. BERMAN. For Medicare providers. I am talking about for all medical providers.

Dr. FALCON. Yes, sir, I understand that, but there is already a system in place that provides what you are asking about to a small segment of the population.

Mr. BERMAN. Explain to me. Does it have the ability to delicense doctors?

Dr. FALCON. Yes, sir, it does.

Mr. BERMAN. Show me where.

Dr. FALCON. OK. Basically what happens is that if, after a chart review, it is found that a physician has a quality problem and the quality problems are tiered into level 1, level 2, and level 3, where level 3 puts the patient at significant risk and possibly death, those are reviewed by the State committee. Less of the quality problems are reviewed at the regional committees.

If after a hearing with that physician we find that he has a significant deficit in his fund of knowledge, then that physician—that recommendation from the panel is turned over to the Office of the Inspector General, and I can think of probably at least 40 cases where we have sanctioned physicians to not to be able to see medicare patients for the rest of their lives, and probably another 60 to 100 that have voluntarily turned in their licenses and retired.

Mr. BERMAN. Do you support extending and insuring a nonphysician dominated agency to delicense physicians with Federal standards applying to all 50 States, taking over the licensure functions or setting the standards for licensing for all 50 States?

Dr. FALCON. I would hope that if a delicensing—I mean a nondoctor committee was going to do that, that there be opportunity for physicians, specifically practicing physicians, to review the chart and make recommendations.

Mr. BERMAN. Sure.

Dr. FALCON. Because sometimes the charts get very complicated technically, and sometimes there are complications that occur as a result of—possible complications from procedures that can be misconstrued by nonphysicians as a quality problem, but that system is in place, and I certainly would favor expansion of that system if that is one of the things that would happen, because that is a system that is fair to physicians.

They are able to come before a committee and defend themselves. In the process—

Mr. BERMAN. Who sits on that committee now?

Dr. FALCON. I am one of the seven members that sit on that committee.

Mr. BERMAN. How many nonphysicians are on that committee?

Dr. FALCON. We have no nonphysicians on that committee.

Mr. BERMAN. And what is your jurisdiction of review?

Dr. FALCON. At present, it involves medicare patients and approximately 200 other—

Mr. BERMAN. What physicians do you have jurisdiction over?

Dr. FALCON. Any physician that is taking care of a Medicare beneficiary.

Mr. BERMAN. In what area?

Dr. FALCON. Any area.

Mr. BERMAN. Of the country?

Dr. FALCON. Our PRO is limited to the State of Texas, each state has a PRO.

Mr. BERMAN. You are one of seven people for the entire State, all physicians?

Dr. FALCON. Yes, sir. And I believe that they are all physicians because that is what the law calls for.

Mr. BERMAN. Ms. Wittkin, what is your feeling about federalizing all this as part of the quid pro quo and how would you change things?

Ms. WITTKIN. I certainly think that we need to do something to make the State medical boards consistent, sort of homogeneous entities in that if you lose your license, because you are too dangerous to practice in one State, you are too dangerous to practice in any State.

If you move out of the State and you want to come back in, States won't just accept your registration fee and allow you to walk back in and worry about what you did for the last 5 years, later.

There are a lot of things that we can do to standardize what State medical boards must do, which I think will have an enormous impact on the quality of health care, but they are only one part of this program and one part of the picture of quality and patients' rights and consumer protection.

I just have to say in response to the discussion on the PRO's, that the Federal peer review organizations were blasted for being embarrassingly inadequate programs for this country. The money is misused. You are talking about millions and millions of dollars thrown into this program.

In this entire country since the PRO program has been in place, maybe 10 or 20 doctors have been sanctioned by the program, which means that they have lost their ability to receive Medicare reimbursements from patients. There is no mandate or requirement in Federal law that says that those cases must then be reported to the State medical board for further disciplinary review.

It is totally up to the individual PRO which is run by doctors, largely medical societies within a State, to decide what to do with that. So most of the cases where there has been an action against a doctor, information about a potentially dangerous doctor through the PRO program is never referred automatically to the State medical board for a comprehensive review and investigation of that doctor's practice patterns.

In addition to that, doctors have so many layers of due process in the PRO program that it is outrageous. We deal with senior citizens all the time who are very scared, and they are scared for a variety of very legitimate reasons.

If they have been harmed by poor care and they want to complain, they are afraid of retribution. They are afraid of not being able to go back to that emergency room or that hospital or that doctor, but those that have the courage to file a complaint with one of these PRO's is then frustrated because under the Federal law, the doctor gets to decide whether you as a complainant have a right to see the outcome of the investigation, and if the outcome of the investigation is that the doctor has been sanctioned or placed in some remedial program or subject to a more comprehensive review, that accountability is very important.

People need to know that they didn't lose a family member for no reason and that something that they do is going to help correct a problem, and in the PRO program, what happens is that people come forward but they never find out the result of their complaint.

Mr. BERMAN. Thank you. Your comments are very helpful. There are other people who would like to question. Let me just finish with two questions.

One, to the three physicians, do you think a \$250,000 cap for pain and suffering, without regard to what happened to the patient and what the reason for that was, is a fair limitation in all situations?

Dr. KELLER. I have previously said no.

Mr. BERMAN. I thought that is—

Dr. KELLER. There does need to be a schedule that needs to be developed. It is not a simple thing to do, but there should be categories, if you will, recognizing the severity of injury that should not necessarily relate to negligence or liability but just to the patients situation.

We do suggest that that will take a while to develop and in the meantime, one might consider more rigid caps on the way to a better system.

Mr. BERMAN. Dr. Hannan.

Dr. HANNAN. Yes, sir. I would like to argue the opposite point, and I would say that in the current medical practice and malpractice environment, that such a cap is fair.

Now, it may appear to be unfair in the individual case, but when you look at what is happening in this Nation in terms of health care costs and what the reasons are for the increase in health care cost, it has to do with malpractice as one of many components.

Mr. BERMAN. Prove that case. Tell me why California, which has the \$250,000 caps, tell me why California's health care inflation index is no better than anywhere else in the country and frankly, California is probably as high a health care cost area, at least until the last two years or so, as any other part of the country.

Dr. HANNAN. I would like to state that in a recent Families U.S.A. Study, that the average New York family's health care costs in 1991 were \$5,585. While in California, it was \$4,433. That is \$1,100 a year difference.

Mr. BERMAN. What was the differential in 1975?

Dr. HANNAN. I don't have that information.

Mr. BERMAN. I would be willing to review everything if you could show me that the medical malpractice changes in California substantially assisted California patients in reducing their health care costs. Then I think we can make some balancing judgments.

Not right now, but I would be very interested in seeing that evidence.

Dr. HANNAN. There are many factors other than malpractice which go into play in terms of what these costs were based on, but I think, getting back to your original question, what is fair, I think it has been totally ignored by this panel that when an individual is compensated, society pays.

You may think you are getting into the deep pockets of the hospital and the physician, and you may drive an individual physician into bankruptcy, fairly or unfairly, whether this was professional misconduct or not, but if a verdict is malpractice and it goes to the insurance company, the insurance company pays, the rates go up, the office visits and the surgical fees increase.

It is society that is paying, and if you are going to look at getting control of Federal health care costs in a system that is federally dominated, there has to be at this time a cap on noneconomic damages in order for the tort system to be applied fairly to all of the alleged victims.

Mr. GOODLATTE. Would the gentleman yield?

Mr. BERMAN. Sure I would.

Mr. GOODLATE. Dr. Hannan, the information that I have in regard to your point, it doesn't go directly to that, but we show, and I am sure we can make these figures available to you, that California's professional liability insurance premiums were the highest in the world in 1975; and by 1990, of those premiums one-half to one-third were in States that had not enacted MICRA type reforms.

Mr. BERMAN. If I may reclaim my time, the gentleman missed my point. It was not that the medical malpractice insurance premiums have not gone up less because of those reforms. It is that medical malpractice premiums as a factor in the cost of practicing medicine has been massively overstated by the medical community in its effort to encourage the Congress to federalize the tort law and adopt the California law as the national law. Not that the premiums—I agree completely with the statistics the gentleman cited.

California malpractice premiums have basically stabilized because of the very rigid caps. California health care costs have not stabilized. They have gone up massively.

Mr. GOODLATTE. If you would yield further, I would be interested in seeing the same information that you have asked for regarding comparative costs back in 1975 compared to the figures the gentleman just cited, because I would venture a very strong guess that those figures would not compare the same way then that they do now in such a favorable light. Eleven hundred dollars or a 20-percent reduction is pretty substantial.

Mr. CONYERS [presiding]. Mr. Berman, are you nearly concluded?

Mr. BERMAN. I am.

Mr. CONYERS. All right. Could we recognize the gentleman from Virginia for a while and then we want to get to Mr. Scott of Virginia before we close down. So we would appreciate just taking a few minutes.

Mr. GOODLATTE. I will be brief. Thank you, Mr. Chairman. Mr. Corboy, as a former member of the American Bar Association, I was interested in the ABA's position on issues. I do not agree with the issue we have just discussed. I think that some form of a sliding scale cap on noneconomic losses would be appropriate.

But I do agree with you on at least a couple of the other areas. The alternative dispute resolution mechanism, perhaps including mandatory arbitration, I think, would be a significant improvement. I also agree with you, and disagree with the California law, that we should not have price controls on lawyers, which is what a limitation on the contingent fee would be.

However, I am a little concerned about the statement that you made that the American Bar Association has called for universal coverage for all through a common public or a public/private mechanism because every one of the plans that have been offered to this Congress that include guaranteed universal coverage also include some form of price controls on doctors. I wonder if you can square the position of the ABA with the fact that price controls being undesirable for lawyers which I believe would also be undesirable for doctors.

Mr. CORBOY. I can't, Congressman, because I frankly am not privy to the differentiations between the various congressional bills and Senate bills that are before all of you folks.

I am not professing to be even remotely capable of recommending what type of universal health care to supply you. I just don't know the answer because I have not studied it. I suggest, if I have any expertise, it is in the area of malpractice tort reform or malpractice deformation.

Could I supply another answer to you, though, that we have supplied in our written statement? Our exhibit, it is appendix C, specifically points out what has happened in California concerning costs. The increase of medical expenses, not premiums, medical expenses, has gone up 99 percent in California over a 9-year period. California is the second ranking State with health care costs increasing from 1982 to 1990, and if you look at the document we have supplied you, you will see that the 1982 cost per family was \$1,451.

In 1990, it is \$2,894, which is an increase of 99 percent. I again suggest we have given an answer to the inquiry that was made. What effect has tort changes had on the cost of medical care in California, and the answer is, it has had absolutely no effect other than to allow an increase since 1982 of 99 percent.

Mr. GOODLATTE. Well, let me point out, however, that the MICRA reforms went into effect 7 years before—

Mr. CORBOY. Yes, sir.

Mr. GOODLATTE [continuing]. This study was performed, and therefore, the impact of that would already have been felt by the time—

Mr. CORBOY. But you know how long it takes the impact of any tort system? It doesn't affect pending cases until those cases are gone.

Mr. GOODLATTE. Let me turn the tables on the physicians now and ask them and say to you that I would like to hear the ABA's further opinion on price controls on physicians. Let me suggest to

you that when the President of the United States says he is going to give everybody a plastic card that assures them all the health care coverage that they are ever going to need, that it is going to place an unprecedented demand on health care providers. It is the President's plan that creates the necessity of price controls.

We have price controls on some government programs in place right now. If you go and add additional government programs, you are going to make more price controls necessary. I am not in favor of that, but I would like to ask the physicians, given that, do you favor price controls on the lawyers in these cases?

Dr. HANNAN. It is the position of both the American Medical Association and the Medical Society of the State of New York that there be a limit on contingency fees, and in New York, we have had that as one of the components since 1985.

I think it has been fair and equitable. I think that it has got to be one of the components of tort reform at the Federal level. It is in the President's plan, although the proposal that is in H.R. 3600 is more generous to the plaintiff's attorney than what is currently legislated in New York.

Mr. GOODLATTE. I would encourage you to reconsider that as well. I think you are both trying to get both what you want and what you don't want. Let me ask you, Mr. Keener.

Mr. CORBOY. Can I give you some thought on that, Congressman?

Mr. GOODLATTE. Sure.

Mr. CORBOY. I think it would be unfair for me to sit here and not supply the fact that I have written a law review article which a few people have read. It was in *Litigation Magazine* of 1976. That is how old it is.

This is not a new issue, and I came out with a bold statement and backed it up with some persuasion that, again, not many people have read about perhaps. I don't believe any contingent fee should be in excess of a third.

I just don't—I would think it would be unconscionable for it to be more than a third. A lot of lawyers disagree with me, but I think the marketplace makes up for it.

Those cases that you charge a third on and you make more money than you perhaps should in—that you might be expected to in a given case, you satisfy it by losing and having cases where the recovery is very small and you are still restricted.

Mr. GOODLATTE. But what about that small case—Ms. Wittkin may want to address this—where the lawyer finds it far more economical simply to pass it by and only work on those larger cases where a one-third fee might be sufficient remuneration, and when you are talking about something as complex as medical malpractice, a case where the specials, the medical loss, and other out-of-pocket loss is small, or in the thousands or tens of thousands of dollars, it may be just as complicated to prove the liability there as in a case where the specials may be in the hundreds of thousands or millions of dollars, and where one-third may be a perfectly good or maybe even too high.

Mr. CORBOY. You are absolutely correct, sir, and they are a neglected set of tort victims. Those people are neglected completely. They just do not get lawyers because lawyers cannot only not af-

ford to take the case. They can't afford to sponsor the case financially because of the cost of litigation and expert testimony, et cetera, et cetera, et cetera.

Mr. GOODLATTE. I do think mandatory arbitration might help some in that regard.

Mr. CORBOY. Again, though, mandatory arbitration is expensive. The costs of mandatory arbitration are the same as the costs of trial except for the filing of the suit and the filing of the jury demand.

Doctors are going to charge just as much to appear. Witnesses are going to charge just as much to appear, and I don't know if the mandatory arbitration system will have discovery, but if it has discovery, it is going to cost just as much as if it goes to court.

Mr. GOODLATTE. Let me ask one more question if I may, Mr. Chairman.

Mr. Keener, you had mentioned that your experience in California and by the way, I have a family member who is a professional liability defense attorney in Stockton, CA, who gives me a different impression of the success of the California reforms, but nonetheless, you say that 80 percent of the verdicts are successful on behalf of the defendants.

Mr. KEENER. Yes.

Mr. GOODLATTE. Tell me further, in your opinion, how many cases are settled out of court for a de minimis amount where the case is nonmeritorious?

Mr. KEENER. I am not sure I can give you a number on that. I can tell you that about 40 percent go away completely without any payment at all.

Mr. GOODLATTE. After suit is filed?

Mr. KEENER. After suit is filed.

Mr. GOODLATTE. There is a substantial amount of cost incurred, both by that plaintiff, the plaintiff's attorney, and by the defense and the insurance companies, so on, before that takes place in many instances, I would suspect.

Mr. KEENER. In many instances, that is right. These cases are very expensive.

Mr. GOODLATTE. Let me ask everybody, and again, Ms. Wittkin may want to jump in to address this as well, what do all of you think about requiring the loser in these proceedings to pay something. Many States provide some minimal court costs to be paid. In Virginia, for example, it is not even the cost of depositions, but maybe the cost of the jury and the cost of filing the suit and so on that might be awarded to the prevailing party. What do you think about this idea? I believe you have got to limit it because otherwise an insurance company or somebody spending a great deal of money in the suit might simply price plaintiffs out of the market, but what do you think about requiring physicians to pay the attorneys' fees or some reasonable award to the prevailing plaintiffs and conversely, requiring plaintiffs who do not prevail to pay something toward the cost of the attorneys—the attorneys' fees of the physicians?

Ms. Wittkin, I will give it to you first.

Ms. WITTKIN. Well, unfortunately, based on the New Jersey study by the American College of Physicians, which shows that 60

percent of nonmeritorious doctor defense cases are won by defendants at trial, I would say that that is an outrageously bad thing to happen to medical consumers and to victims.

What we have here are too many frivolous suits on the other end and we are not looking at it.

Mr. GOODLATTE. What do you mean by that?

Ms. WITTKIN. I mean that victims lose cases more often as a result of just good, slick defense work, the ability to spend unlimited funds as opposed to what many of the plaintiff attorneys can spend on cases, and, in many instances, you are talking about perjury, you are talking about altered records, you are talking about fraud.

Those things go hand in hand with medical malpractice and anyone who tells you it doesn't is—you know, is just not being truthful. Most cases get settled. Well over 90 percent of the cases are settled before they ever go to jury trial and a good, maybe another 5 or 6 percent are settled before you get a verdict.

So most of the cases never get into the jury system. But the ones that are getting into the jury system, in 60 percent of the instances where the doctors are flat out guilty of malpractice, they are winning those cases.

Mr. GOODLATTE. Can you supply us with some statistics that show that what you claim is correct—that there is a high percentage of cases where physicians should lose, but they actually win?

Ms. WITTKIN. Yes. The journal, the *Annals of Internal Medicine*, published the report by the American College of Physicians last year. I will be happy to supply you with that, along with the letters to the editor by outraged doctors over the 5 or 10 percent of cost of frivolous plaintiffs' suits and the admonishment by the authors of the study, about the fact that those doctors totally missed the fact that 60 percent of their indefensible cases were being won by them at trial.

I would further just like to say that over this same American College of Physicians study, which looked at 15 years of malpractice experience in New Jersey, also found that even though a large portion of the claims are closed without payment, over 70 percent of those cases are closed either before discovery, or before discovery is completed, so there is not an enormous expense.

Large expenses are incurred in cases that drag out for years and years and end up in the court system. Most cases, however, are disposed of very quickly.

[The information follows:]

The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims

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■ **Objective:** To explore how frequently physicians lose medical malpractice cases despite providing standard care and to assess whether severity of patient injury influences the frequency of plaintiff payment.

■ **Design:** Retrospective cohort study.

■ **Setting:** Physicians from the state of New Jersey insured by one insurance company from 1977 to 1992.

■ **Participants:** A total of 12 829 physicians involved in 8231 closed malpractice cases.

■ **Measurements:** Physician care and claim severity were prospectively determined by the insurance company using a standard process.

■ **Results:** Physician care was considered defensible in 62% of the cases and indefensible in 25% of the cases, in almost half of which the physician admitted error. In the remaining 13% of cases, it was unclear whether physician care was defensible. The plaintiff received a payment in 43% of all cases. Payment was made 21% of the time if physician care was considered defensible, 91% if considered indefensible, and 59% if considered unclear. The severity of the injury was classified as low, medium, or high in 28%, 47%, and 25% of the cases, respectively. Severity of injury had a small but significant association ($P < 0.001$) with the frequency of plaintiff payment (low severity, 39%; medium severity, 43%; and high severity, 47%). The severity of injury was not associated with the payment rate in cases resolved by a jury (low severity, 23%; medium severity, 25%; and high severity, 23%).

■ **Conclusions:** In malpractice cases, physicians provide care that is usually defensible. The defensibility of the case and not the severity of patient injury predominantly influences whether any payment is made. Even in cases that require a jury verdict, the severity of patient injury has little effect on whether any payment is made. Our findings suggest that unjustified payments are probably uncommon.

The fear of medical malpractice has resulted in significant physician dissatisfaction and has contributed to the decrease in the number of persons entering the field of medicine (1, 2). Further, physicians have stimulated legislation for tort reform, increased the practice of defensive medicine, and avoided "risky" patients (3-7).

Physicians' apprehensions about malpractice stem from several perceptions (7). Perhaps foremost is the concern that the malpractice resolution process is unfair (8). Because standards are unclear and possibly inconsistent, physicians are afraid of being sued and of losing the case despite their having provided standard medical care (9). Further, juries are seen as unjustifiably rewarding patients solely on account of the severity of their injuries.

We explored the influence of physician care and the severity of patient injury on the malpractice process. Contrary to many perceptions, our study suggests that physicians usually win cases in which physician care was deemed to meet community standards and that the severity of patient injury has little bearing on whether a physician loses a case.

Methods

Data Source

We obtained our data from The New Jersey Medical Inter-Insurance Exchange, a physician-owned insurance company. This company insures approximately 60% of the physicians in New Jersey. Since 1977, demographic information on physicians and detailed descriptive information on every malpractice claim have been entered into a standardized computer database.

Study Design and Population

We did a retrospective cohort study that included physicians insured for any time between 1977 and 1992. During this period, 12 829 physicians were insured and 11 934 cases were filed, of which 80% are currently closed. Because the time from an incident until its resolution can vary greatly, we chose 1 January 1986 as a cutoff point for the incident date because 96% of cases that occurred before this date were closed by 1992. After excluding 14 cases that lacked peer review results, we evaluated 8231 closed cases.

Study Variables

The insurance company's assessment of whether a physician's actions represent standard medical care is based on medical criteria and is not supposed to be influenced by legal concerns. First, the physician is contacted, and if he or she admits error, the case is labeled "indefensible—insured admits deviation," and no further review is done. Otherwise, the case is reviewed by a claims representative employed by the insurance company. If the physician's performance is thought to be clearly medically defensible, the case is labeled "no peer review, clearly defensible." Otherwise, a peer review process ensues in which a physician from the same specialty is chosen

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from volunteer physicians, many of whom have performed this service regularly for several years. This physician-reviewer then participates in a discussion of the case with the claims representative, the defense attorney, and the defending physician or physicians. Based on the standard of medical care currently practiced by physicians of similar training and experience in the community, the physician-reviewer classifies the claim as "defensible" if standard care was provided, "indefensible" if not, and "defensibility unclear" if the reviewer is unsure. A slight variance to this standard procedure occurs for neurosurgery and orthopedics cases because, historically, experts hold divergent opinions about the appropriate approach to some routine problems. Therefore, a panel of physicians is used instead of one physician-reviewer, and the majority vote is considered final. For every case, we summarized this process of the assessment of physician care as defensible, indefensible, or unclear.

If a plaintiff receives financial compensation through either a settlement or a jury verdict, the terminology "payment" is applied. For the subset of payments resulting from a jury verdict, the term "award" is used. We created four categories of payment: less than \$10 000; \$10 000 to \$49 999; \$50 000 to \$199 999; and \$200 000 or more. All dollar amounts are adjusted to represent 1990 dollars.

The insurance company classifies the severity of the patient's injury using the industry standard National Association of Insurance Commissioners Index (10). This index has nine categories of increasing severity. We collapsed this into three categories: low (no injury, minor injury with no disability, or minor injury with temporary disability); medium (major injury with temporary disability, minor injury with moderate disability, or major injury with moderate disability); and high (grave injury with moderate disability, brain injury with impaired life expectancy, or death).

The stage of resolution is the point in the legal process at which the case is resolved. A case is created when the insurance company is notified of a plaintiff's claim of damages. A suit occurs when this complaint is filed with the court. Discovery refers to the process by which lawyers collect information about the case.

Statistical Analysis

Statistical significance was assessed by chi-square tests as appropriate (11).

Results

The characteristics of the 8231 closed cases are summarized in Table 1. Physician care was considered defensible in 62% of the cases and indefensible in 25%. In almost half of the latter cases, the physician admitted error. The remaining 13% of cases were unclear as to defensibility. Payment was made in 43% of all cases, with 52% for less than \$50 000 and only 15% for greater than \$200 000. The median payment was \$45 551 (range, \$24 to \$3 965 000). The severity of the injury was classified as low in 28% of cases, medium in 47%, and high in 25%.

Physician Care

Evaluation of physician care correlated closely with the likelihood of financial payment. A payment was made in 21% of the cases considered defensible, in 91% of the cases considered indefensible, and in 59% of the cases considered unclear. The amount was not directly related to judgments of defensibility ($P = 0.16$ [for linear trend]).

Most cases closed early in the process (Figure 1); 67% were closed before discovery was completed. Only

Table 1. Medical Malpractice Claim Factors

Factor	Closed Cases (n = 8231) n (%)
Physician care	
Defensible	5132 (62)
No peer review, clearly defensible	2378 (29)
Insured found defensible by peer review	2754 (33)
Indefensible	2000 (25)
No peer review held, insured admits deviation	881 (11)
Indefensible (breach of standard)	1119 (14)
Unclear	1099 (13)
Payment	
No	4730 (57)
Yes	3515 (43)
< \$10 000	744 (21)
\$10 000 to < \$50 000	1089 (31)
\$50 000 to < \$200 000	1141 (33)
\$200 000 or more	541 (15)
Severity of injury	
Low (no injury or minor injury with no or temporary disability)	2334 (28)
Medium (minor or major injury with moderate disability or major injury with temporary disability)	3824 (47)
High (grave injury, brain injury, or death)	2087 (25)

one quarter of the 12% of cases requiring a jury verdict resulted in payment to the plaintiff. Of these awards, the median payment was \$114 170 (range, \$3281 to \$2 576 377). For each stage, the percent of cases that resulted in payment strongly correlated with physician care ($P < 0.001$). For example, in those cases that closed before a suit was filed, payment was made to the plaintiff in 6% of defensible cases, in 69% of cases in which physician care was deemed unclear, and in 93% of indefensible cases. In addition, physician care influenced the stage of resolution. A jury verdict was required for 15% of defensible cases, for 10% of cases in which defensibility was unclear, but in only 5% of indefensible cases ($P < 0.001$ [for linear trend]). Even in the 12% of cases that required a jury verdict, physician care correlated with the likelihood of a jury award: 21% if defensible, 30% if unclear, and 42% if indefensible ($P < 0.001$ [for linear trend]).

Severity of Injury

The influence of the severity of the claimant's injury on the resolution process is summarized in Table 2. A similar distribution of physician care was seen in every severity category. The likelihood of obtaining any payment showed a small (< 8% difference between low and high claim severity) but statistically significant ($P < 0.001$) trend toward an association between increasing severity and the likelihood of payment. These findings remained consistent when all nine severity-of-injury levels were analyzed.

The amount of payment correlated closely with the severity of the injury. The median payments for injuries of low, medium, and high severity were \$7189, \$50 000, and \$115 089, respectively. These findings also remained consistent when all nine severity-of-injury levels were analyzed, except in the case of death. In cases of

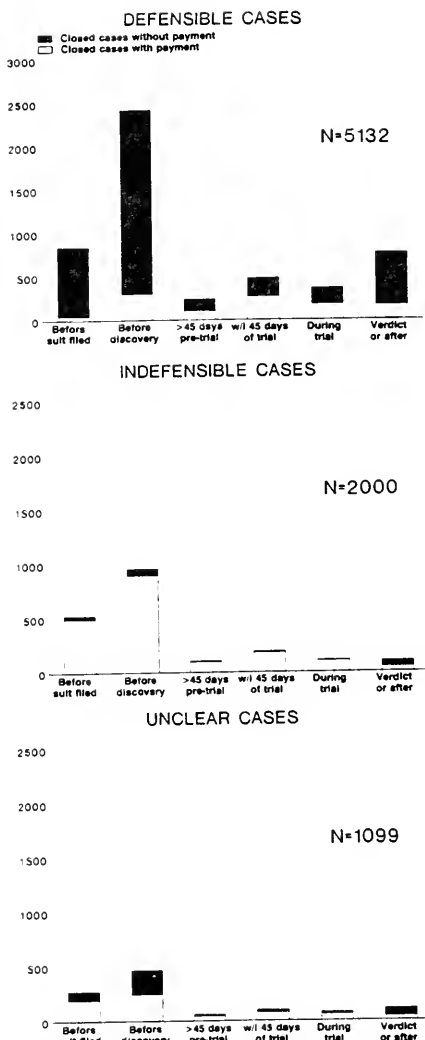


Figure 1. Stage of resolution and payment rate for cases considered defensible, indefensible, or unclear as to defensibility. w/i = within.

death, the median payment was \$94 346, whereas for the remaining high-severity injuries, the median payment was \$210 807.

In contrast to the overall findings, in cases requiring a jury verdict, the severity of injury was not related to

the likelihood of payment ($P > 0.2$). However, the severity of the injury did correlate with the payment amount ($P = 0.03$) (Table 3).

Discussion

In most of the malpractice cases included in our analysis, a physician was judged to have provided medical care that was defensible, and the plaintiff did not receive any payment. Although physician care strongly influenced the overall process, the severity of the patient injury had little effect on the probability of any payment. Most cases closed at an early stage, so a jury verdict was rarely needed. For the small number of cases that required a jury verdict, only 24% resulted in payment to the plaintiff and the severity of injury did not influence the probability of payment.

The determination of physician care was a good predictor of the outcome of a case. For the cases that were felt to be indefensible, the payment rate was 91%. This high payment rate is expected because the insurance company uses the determination of physician care to decide whether to offer to settle a case. In contrast, in the cases where physician care was classified as defensible, the payment rate was 21%.

Several factors may explain why payment occurred in cases classified as defensible. First, the determination about physician care was made very early after a claim was generated and may have been inaccurate as more information became available. Second, a physician-based review process may be biased toward assessing physician performance in the physician's favor. Third, the insurance company may err toward an initial determination of physician care as defensible to avoid unnecessary payments. The possibility that new information rendered the original assessment of defensibility incorrect was supported by the fact that 68% of defensible cases that resulted in payment were settled before trial, in half of these before discovery was complete. Further, only 15% of defensible cases that resulted in payment represented awards made to the plaintiff by a jury. In addition, because the physician has the right to refuse to settle and the insurance company is physician-owned, many of the defensible cases that resulted in payment were probably misclassified as defensible. Therefore, although we can only speculate on the number of cases that were inappropriately lost by the physician, our data suggest that inappropriate payments are probably uncommon.

Severity of Injury

Although the findings of previous studies are inconsistent (7, 8, 12, 13), we found that the severity of patient injury had little influence on the probability of plaintiff payment. We anticipated that a jury would be more likely to rule in favor of the plaintiff if the patient had a more severe injury. Similarly, we expected that the plaintiff's attorney might negotiate a payment for the plaintiff more frequently in cases in which injury was of higher severity than in those in which injury was of lower severity.

We also found that the assessment of the standard of

Table 2. Relation between Severity of Injury and Physician Care, Payment, and Stage of Resolution

Variable	Severity of Injury		
	Low (n = 2326)	Medium (n = 3820)	High (n = 2085)
	n(%)		
Physician care			
Defensible	1407 (61)	2456 (64)	1269 (61)
Indefensible	525 (23)	907 (24)	568 (27)
Unclear	394 (17)	457 (12)	248 (12)
Payment			
No	1420 (61)	2186 (57)	1111 (53)
Yes	906 (39)	1634 (43)	974 (47)
< \$10 000	521 (23)	181 (5)	41 (2)
\$10 000 to < \$50 000	276 (12)	634 (17)	179 (9)
\$50 000 to < \$200 000	97 (4)	637 (17)	407 (20)
\$200 000 or more	12 (1)	182 (5)	347 (17)
Stage of resolution			
Before suit filed	891 (38)	544 (14)	219 (11)
After suit, before discovery complete	930 (40)	1927 (50)	1005 (48)
After discovery, more than 45 days before trial	80 (3)	189 (5)	142 (7)
Within 45 days of trial	140 (6)	395 (10)	238 (11)
During trial, before verdict	102 (4)	270 (7)	186 (9)
Verdict or after	182 (8)	497 (13)	296 (14)

care by a peer review panel was not related to the severity of injury. This finding differs from that of a recent study, which found that the patient's outcome strongly influenced reviewers' opinions of the appropriateness of care (14). The contradictory findings may reflect the fact that the physician-reviewers in that study had only abstracted data of selected cases. In our study, the malpractice cases were judged during the actual processing of the case, with the medical records available for review and with the treating physician available for additional insight.

We suspect that our results can be generalized even though our study was done in a subset of physicians from one state. In a previous study, we found that the demographic characteristics of the physicians in our database were similar to the overall population of physicians in New Jersey and varied only slightly from national figures (10, 15, 16). In addition, the frequency of payment, average amount of payment, severity of injury, stage of resolution, and proportion of claims involving only one physician are consistent with the findings of other studies (10, 13, 17). Thus, despite the implicit nature of judgments about defensibility, our

results should be generalizable to other physician-patient populations.

These results have implications for tort reform. This insurance company felt liability was unclear for only 13% of cases, and a jury verdict was required for only 12% of all cases. This suggests that much of the efforts in the malpractice process involves determining the facts of the case and negotiating the amount of settlement rather than resolving disagreements about the presence of liability. Neither the patient nor the physician is served by this extremely inefficient and costly process, which results in delayed payments to injured parties and casts a prolonged cloud over physicians. Our experience in determining physician defensibility suggests that arbitration panels may be successful in assessing liability. Unfortunately, our data shed little light on the costs and benefits of a "no-fault" system because most injuries do not enter the current malpractice resolution process (18).

In summary, our analyses suggest that, in malpractice cases, the physician's care is usually defensible and that the plaintiff usually does not receive any payment. The severity of patient injury affects the payment amount

Table 3. Cases Requiring a Verdict: Relation of Physician Care and Injury Severity to Final Award Status

Variable	Award			Payment				
	No	Yes	Total	< \$10 000	\$10 000 to < \$50 000	\$50 000 to < \$200 000	\$200 000 or more	Total
	(n = 740)	(n = 236)		n(%)				
Physician care								
Defensible	605 (79)	161 (21)	766 (100)	8 (5)	33 (20)	62 (39)	58 (36)	161 (100)
Indefensible	59 (58)	42 (42)	101 (100)	0 (0)	8 (19)	13 (31)	21 (50)	42 (100)
Unclear	76 (70)	33 (30)	109 (100)	2 (6)	8 (24)	11 (33)	12 (36)	33 (100)
Severity								
Low	141 (77)	42 (23)	183 (100)	3 (7)	15 (36)	16 (35)	8 (19)	42 (100)
Medium	372 (75)	125 (25)	497 (100)	5 (4)	24 (19)	52 (42)	44 (35)	125 (100)
High	227 (77)	69 (23)	296 (100)	2 (3)	10 (14)	18 (26)	39 (57)	69 (100)

but has little influence on whether monetary damages are received by a plaintiff, especially in cases that are decided by a jury. Further efforts to clarify the frequency of unjustified payments are needed, but our data suggest that such payments are uncommon.

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Checklist for Dietary Assessment Methods

To the Editors: The United Kingdom Nutritional Epidemiology Group is an informal group of individuals in research institutes and academic departments involved in the measurement of dietary intake and in research into appropriate methods for such measurement. This group proposes that a consistent standard of editing of articles on nutrition be widely adopted. We have drawn up a checklist of information necessary for a dietary assessment method to be adequately described. The checklist has been or is being published in 1993 in the following journals: *British Journal of Nutrition*, *Metabolism*, *Journal of Nutrition*, *Australian Journal of Nutrition and Dietetics*, *Journal of Tropical Pediatrics*, *Acta Paediatrica*, *International Journal of Epidemiology*, *European Journal of Clinical Nutrition*, and *Journal of Human Nutrition and Dietetics*.

We ask that authors consult the checklist before submitting articles on nutrition for publication. We also recommend that authors include in full any questionnaires used (even if much reduced in size) as an appendix, or give a reference if it has already been published. If publication is not practical, we suggest that the authors be required to submit a copy of any questionnaire used for purposes of peer review.

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The Medical Malpractice System

To the Editors: A critical review of Taragin and colleagues' (1) useful analysis of data on medical malpractice cases in the state of New Jersey is not so reassuring. Between 1977 and 1992, there were 12 829 insured physicians, and 11 934 cases were filed. The data analysis on 8231 closed cases, which had been prereviewed by insurance company medical experts, showed that 62% of these cases were "defensible"; that is, there was no clear evidence of physician error. Because a malpractice claim can seriously disrupt a physician's personal and professional life and can cause him or her significant "emotional distress," even when the case is eventually resolved in the physician's favor, this percentage is distressingly high.

Even more disturbing is the fact that payments were made in 21% of the cases classified as defensible. Although Taragin and colleagues suggest the possibility of misclassification, it is also possible that the insurance companies paid the plaintiffs to go away, deciding it was less expensive than defending the case in court, even if ultimately successful.

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Reference

1. Taragin MI, Willett LR, Wilczek AP, Trout R, Carson JL. The influence of standard of care and severity of injury on the resolution of medical malpractice claims. *Ann Intern Med.* 1992;117:780-4.

To the Editors: The timely discussion of malpractice issues (1, 2) was cogent but totally failed to address two major as-

pects of the liability problem. First is the inhibition of scientific progress and public health, as shown by industry's demands for indemnification of liability risks for research and development (3). Second, the failure of a workable countersuit available to defendants encourages a proliferation of litigation, as plaintiffs and their attorneys can function without fear of responsibility for filing suits without merit. Corrective legislation in both areas is sorely needed.

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3. Cotton P. Infants, science may lose as liability is blamed for company pullout from HIV prevention trial [News]. *JAMA.* 1992;268:1991-2.

To the Editors: Taragin and coworkers (1) investigated the medical malpractice tort system through use of closed claims data from the Medical Inter-Insurance Exchange of New Jersey. They presented the conclusion that physician care in malpractice cases is usually defensible and suggested that unjustified payments are probably uncommon. Their findings are generally consistent with the American Society of Anesthesiologists' study of 1004 closed anesthesia malpractice claims (2). Their study, however, differed from ours and others (3) in one important aspect: In their study the standard of care assessment was not associated with severity of injury. In contrast, we found that in cases of severe injury, care was more commonly assessed as substandard, whereas in cases of non-disabling injuries, care was more commonly assessed as meeting standards (2). We subsequently found in an experimental study that knowledge of severity of injury influenced anesthesiologist reviewers' judgments of the appropriateness of care (4).

One possible explanation is the difference in sampling: Taragin and colleagues studied claims from a single state; we studied a national sample with claims from 17 insurance companies (including the source of Taragin and colleagues' claims). Taragin and colleagues studied all medical malpractice claims; we studied only anesthesia-related claims. A second explanation concerns how "defensibility" was defined and assessed. The two studies did not use identical definitions of "defensibility" (1) or "appropriateness of care" (2). Although peer reviewers in both studies had access to complete files, only in Taragin and colleagues' study did the reviewer have access to the defendant and defense attorney. Another explanation is that reviewer bias may be more common among anesthesiologists than other specialists because of the nature of anesthesia practice. The goal of anesthesia is usually to enable or facilitate therapy, not to provide a treatment or cure in itself. The avoidance of unnecessary side effects and poor outcomes is a fundamental and highly valued objective (4). If outcome bias in judgments about standard of care is specialty specific, then specialty-specific data are required.

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To the Editors: The 21% payment rate in cases where physician care was defensible contradicts the conclusion that unjustified payments are probably uncommon. I propose an alternative analysis of the data. Exorbitant awards are commonplace and can exceed a physician's coverage. The litigation itself is an agonizing process that drags on for years. Juries do not understand medical problems, especially those that are difficult or complex, and their decisions are arbitrary. These forces frequently lead to "token settlements," which maintain privacy and are much less expensive and risky than jury trials.

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To the Editors: *Annals* should be commended for publishing articles such as that by Taragin and associates (1) and the companion editorial by Bovbjerg (2). Yet, too little attention has been given to the problem of medical prostitution, a problem I encounter frequently in my practice, which is limited to the defense of health professionals and health care institutions accused of malpractice. An emergency physician testified that, on the strength of a chest roentgenogram alone, he was able to diagnose pneumococcal pneumonia. A family practitioner testified that she knew the standard of care for an orthopedist because she had taken an orthopedics rotation in medical school, had observed orthopedists providing care to her own children, and had discussed the facts of the case at hand with an orthopedist over dinner. An obstetrician-gynecologist testified that a practitioner of his specialty, on the basis of a mid-trimester ultrasound, should have been able to diagnose the hypoglossia-hypodactylia syndrome in a fetus at 20 weeks' gestation.

I could cite numerous other examples; my experience is far from unique. Physicians must understand that 1) a plaintiff unable to identify an "expert" who is prepared to testify to breach and causation does not win the case; 2) integrity is not universal among holders of the MD degree; 3) testifying is for some an occupation unto itself; 4) statements that would be scoffed at by doctors may be believed by lay juries; and 5) unless and until truly massive tort reform is undertaken, and maybe even despite such reform, expert testimony will continue to play a major role in malpractice litigation. In addition, certain companies turn a handsome profit by lining up "experts" to testify against physicians, and some of these organizations actually perform this service on a contingent fee. These facts put the medical profession in a position to do more about the malpractice liability problems than merely to kvetch about it.

If physicians do not police the activities of medical prostitutes, then they must accept at least some of the responsibility for the spread of the malpractice virus. Witnesses such as those I describe bring no credit to law or medicine.

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In response: These letters highlight the fact that medical malpractice is a complex process where simplistic descriptions or solutions always fall short. Dr. Yaes' concern that the number of claims is too many depends on one's perspective (1). Malpractice claims vary greatly among specialties (2). We

agree with Dr. Oppenheimer that the fear of malpractice is a powerful force in U.S. medicine. The prevalence of "medical prostitution" and the possible deterrent effect of filing countersuits are unknown.

One aim of our study was to contrast malpractice perceptions with reality based on the experience of a physician-owned insurance company in New Jersey. We explicitly described how the company initially assesses physician defensibility. We concur with Dr. Posner and colleagues that assessing defensibility is difficult and subject to bias. Whether explicit or implicit standards are used for peer review, it must be recognized that some misclassification will occur (3). Whether misclassification varies with specialty deserves further study. Our hypothesis to explain why 21% of cases initially classified as defensible resulted in payment, namely that these cases were probably misclassified as defensible, is being tested by studying those cases.

The alternative hypotheses proposed by Dr. Lagerquist show the anger that fuels the fires of an already emotionally charged topic. Our work and the work of others clearly show that exorbitant awards are rare (4) and that jury decisions are typically not arbitrary (5). Furthermore, a physician-owned company will not condone and thereby promote "token settlements." No case can be settled without the written consent of the physician defendant.

One of our conclusions with which all seem to agree is that "neither the patient nor the physician is served by this extremely inefficient and costly process, which results in delayed payments to injured parties and casts a prolonged cloud over physicians." Tort reform is needed and requires knowledge about the strengths and weaknesses of the medical malpractice process. For example, although exorbitant awards are rare, the financial and emotional impact to the physicians and insurers is profound.

Our article provides the reader with facts. Not surprisingly, proponents of various causes have used the same data to arrive at different conclusions. We believe that the interpretation and application of these facts should generate hypotheses to be carefully evaluated.

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More on Medical Malpractice

To the Editors: We read with great interest and considerable apprehension the article (1) and accompanying editorial (2) on medical malpractice. Dividing the number of claims filed in New Jersey over a 15-year period (11 934) by the number of physicians insured (12 829) yields an average of 1 case per practicing physician. Further, payment was made in 43% of the cases. If New Jersey is representative of the whole country, then over a 15-year period, 40% of the physicians will have a liability claim against them. Over the professional life time of a physician, there is almost a 100% guarantee that a malpractice claim will not only be filed but won!

Further, in 15% of the cases where the physician action was

defensible, a jury award was made. Would it be tolerable in the criminal justice system if 15% of the persons we send to jail had committed no crime? Neither Taragin and colleagues nor the editorialist chose to comment on these alarming statistics.

Janardan D. Khandekar, MD
Gershon Y. Locker, MD
Evanston Hospital
Evanston, Illinois 60201

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2. Bovbjerg RR. Medical malpractice: folklore, facts, and the future. *Ann Intern Med.* 1992;117:788-91.

To the Editors: In his editorial, Mr. Bovbjerg (1) failed to mention two of the best measures to curtail the myriad medical malpractice suits in the United States:

1. Have plaintiff's attorneys pay all fees and levy stiff penalties for suits deemed "frivolous."
2. Eliminate the antiquated and unfair "contingency fee" remuneration of plaintiff's attorneys. Instead, have them work by an hourly or case rate, as do plumbers, auto mechanics, defense attorneys, and yes, physicians.

Things should change in a hurry.

David R. Neiblum, MD
Paterson, NJ 07503

Reference

1. Bovbjerg RR. Medical malpractice: folklore, facts, and the future. *Ann Intern Med.* 1992;117:788-91.

In response: Taken together, these letters make four points. First, legal performance is unsatisfactory. My editorial agreed, although with different emphasis. Second, the correspondents all find claims much too frequent ("myriad" suits, "alarming" frequency). Claims are certainly high relative to the placid 1950s, when lifetime chance of suit was only 1/7 (1). For 1991, 1.7 was the national average *annual* rate (13.9%, down from all-time high of 17.7% in 1985 [data from the St. Paul Fire & Marine Insurance Co. Personal Communication]). The *typical* doctor's risk of claim is lower, however, because claims are concentrated disproportionately in high-claims areas and specialties, and among repeated defendants. Still, claims remain vastly outnumbered by legitimate negligent injuries. Major studies have found negligent hospital injuries higher by 8:1 or 10:1 (2; see also editorial references). It may seem deplorable that nearly all physicians now can expect to have paid claims sometime in their lives, but almost all motorists do, even though most drive only part-time, whereas most physicians work extra hours.

Third, Drs. Khandekar and Locker profess shock that juries might err in favor of plaintiffs 15% of the time (false-positives in fact were 21% [see Table 3 of article by Taragin and colleagues]). Actually, the far higher rate of errors favoring defendant physicians (false-negative rate of 58%) was not mentioned. Criminal law requires the state to prove guilt beyond any "reasonable doubt," perhaps a 90/10 standard, punishing the innocent seems much worse than leaving the guilty unpunished. In contrast, civil litigation like malpractice only requires a "preponderance of the evidence," roughly, above 50-50. In

such cases, the (alleged) underlying harm has already been done, so the only question is who should bear its costs. Wrongly leaving them on the plaintiff seems equally bad as wrongly shifting them to the defense.

Fourth, Dr. Neiblum suggests moving toward the British rules that losing parties pay winners' costs (although he wants only the losing plaintiffs so burdened and only in "trivial" cases) and that plaintiffs be banned from paying their lawyers through contingency fees (under which only winners pay). Again, note the asymmetry here: added negative incentives for one side of a contingency (losing) but subtraction of a positive incentive for the other (winning). The need for further disincentives to claim may be questioned, given that so few negligently injured patients come forward (2) and that New Jersey doctors are already winning fully 76% of all jury trials, including 79% their insurer thinks they should win and 58% they should lose. Readers should also understand the business aspects of contingency fees. They act like legal-fee insurance for the high costs of litigation. They also make lawyers screen out most would-be cases (3), which should please physicians, although also to seek maximum recovery, which does not. Insurance of litigation expense is taken for granted by defendants, whose premiums are also not only tax deductible but also passed on to patients as higher fees. One can imagine the outcry from physicians at any proposal to make them responsible for all legal fees from their own personal, after-tax resources. In England, only the wealthy and legal-assistance clients have easy access to courts, and many question the system (4). In the United States, legal-aid lawyers are barred from taking personal injury cases, precisely because contingent fees make private-pay lawyers accessible. A less drastic approach is to regulate the high end of legal fees (California style) and to end the unpredictability and potential "jackpot" recovery possible under vague, open-ended rules of figuring damages, especially for "pain and suffering" (5).

Broader reforms are necessary to produce a system that deals with more cases more expeditiously, at lower transaction cost, with greater predictability and consistency of findings, and with a structured rather than open-ended approach to damages, again, especially for pain and suffering. Patients are caught in the crossfire between those doctors who want to declare open season on all the prerogatives tort plaintiffs have accrued over generations and plaintiffs' lawyers who want to retain a profitable, insurance-funded enterprise for top lawyers, but one that yields a minor and delayed compensation for negligently injured patients. Patients and doctors deserve better.

Randall R. Bovbjerg, JD
The Urban Institute
Washington, DC 20037

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Mr. GOODLATTE. Mr. Keener, do you agree with those statistics she cited and what do you think about loser pays?

Mr. KEENER. Let me answer in reverse order. With reference to losers pay, we have in California a provision that the loser pays certain costs, deposition, transcript cost, photocopy. Sometimes those may only be a few thousand dollars. Sometimes they are several thousand dollars.

We have found very few occasions where we have had a plaintiff in a medical malpractice case that frankly had the money to pay it. So the money doesn't get collected.

With reference to her numbers, I really don't know the numbers, but I suspect certainly that just like in the practice of medicine, if you go to an outstanding doctor, your chances of getting better are probably higher than if you go to perhaps a mediocre physician.

Same thing with reference to the results in trial. If you go to an outstanding trial lawyer, the odds are you will get better representation, and that is one of the points we made. The really outstanding plaintiffs' attorneys have left the medical malpractice field because there is too much risk; it costs too much for them to handle them; and the return is just not there.

Ms. WITTKIN. May I briefly respond to that?

Mr. GOODLATTE. Briefly. The chairman wants to move along.

Mr. CONYERS. We have one more Member who has waited very patiently here and has been here as long as anyone.

Mr. GOODLATTE. Mr. Chairman, may I just ask to have Mr. Gekas' statement introduced for the record?

Mr. CONYERS. Without objection, so ordered.

[See appendix 2 for the prepared statement of Mr. Gekas.]

Mr. CONYERS. Let's turn now to Mr. Scott of Virginia.

Mr. SCOTT. Thank you, Mr. Chairman. Our goal here is to try to reduce health care costs, I guess, by reducing the costs of malpractice and improving health care, and it is under that context that I want to ask a couple of questions.

And also in line with what is in the bill, we have talked about a lot of things that aren't in the bill. One thing that is in the bill is alternative dispute resolutions, apparently there is not a lot of controversy about that. It would give some access to the 98 percent that aren't able to file right now. Any controversy about that provision, the other provision?

Ms. WITTKIN. Excuse me?

Mr. SCOTT. Yes.

Ms. WITTKIN. The ADR that is in the bill right now is also something that is going to disadvantage people who are poor, elderly, or have low-end cases, because as long as it is not a binding system, and I am not suggesting that it be binding for all, but as long as it is not a binding system, if the physician or the hospital don't get the outcome that they wish, they can go on to court.

The victim doesn't have that kind of money to go ahead and do that. First, bring on the case through arbitration with experts and review, and then go ahead and go to court. They can't do it, and the doctors and hospitals know they can't do it.

Mr. SCOTT. Can you use the results of the arbitration in—is that admissible in court?

Mr. KEENER. Well, it would depend on the jurisdiction. Certainly the whole concept is settlement, and in most jurisdictions, settlement discussions are never admissible.

Mr. SCOTT. OK. The other areas, the collateral source rule, which we discussed a little earlier, when you have a collateral source, I would like to compare what happens when you have a person with insurance compared to the person without insurance.

We mentioned the \$10 bill. If you have a suit, you collect the \$10. The defendant pays it, the plaintiff gets it, and then pays the bill with it. When you have someone with insurance, somebody who has set aside money every month or every year in case they ever needed hospitalization, the present situation, at least in most States, is that the insurance company pays the bill.

When they receive the recovery, they don't have to pay the bill again, and so the benefit of them having insurance accrues to the plaintiff and they are better off because they have insurance than the person who did not have insurance.

Now, when you get into the collateral source rule and subrogation and everything, there are a number of people at interest. You have got the defendant, you have got the plaintiff, you have got the insurance company. I think the plaintiff, having made arrangements for his possible medical bills, is an appropriate person to receive the benefit of the insurance. I think you can make a case for that.

You could also make a case, in my opinion, for the insurance company. If the next in line, I guess, would be the insurance company because if the plaintiff can pay the bills through the malpractice route, then maybe the insurance company ought to get a windfall and not have to pay the bill.

I think the last person out of the three of interest who would have the windfall, the benefit of the plaintiff's premiums being paid month after month, the last person in line who ought to get the windfall ought to be the person who caused the damage to begin with.

Let me ask, a couple of people supported the introduction of the insurance to offset the award. Can you explain why the tortfeasor in this case ought to receive the benefit of the insurance policy rather than the plaintiff who paid the premium or the innocent insurance company, health insurance company? Why should the tortfeasor receive the benefit?

Dr. Keller.

Dr. KELLER. Our position has been there should not be a double recovery.

Mr. SCOTT. Then who ought to receive the recovery? Why should the tortfeasor rather than Blue Cross-Blue Shield, receive the benefit of the insurance?

Dr. KELLER. We don't think they should. In other words, the insurance company ought to be paid. If it has been paid at the beginning, then the plaintiff should not recover the monies that the insurance company has paid because they may not have to pay them now.

If there is subrogation, then obviously the plaintiff has to write a check to the insurance company for \$10,000 to pay off that hospital bill. But the argument is, I think, if that doesn't happen, then

that bill is added onto the medical care expenditures of the plaintiff, and the jury says they need \$10,000 because they had a hospital bill of \$10,000, we are going to give them \$10,000.

Now, our position is that the plaintiff shouldn't be paid twice.

Mr. SCOTT. Well, then, if the plaintiff doesn't get it, why shouldn't Blue Cross/Blue Shield be reimbursed?

Dr. KELLER. They should.

Mr. SCOTT. They should?

Dr. KELLER. Yes.

Mr. SCOTT. So out of the three people of interest, your position now is that if you are going to deny the plaintiff the benefit of the premiums, then Blue Cross-Blue Shield ought to receive the benefit of the potential windfall?

Dr. KELLER. Well, you can argue it both ways, I guess.

Mr. SCOTT. If there is a windfall, should Blue Cross/Blue Shield get it or should the defendant? We are comparing this to a person who didn't have insurance. You have one who didn't have insurance, there is no question. The defendant pays the \$10.

You have somebody with insurance, and the question is whether Blue Cross/Blue Shield ought to pay the \$10 or the tortfeasor ought to pay the \$10.

Dr. KELLER. To the extent that the Blue Cross company had some legitimate expenditures for the care—let's say that of the \$10, \$5 was appropriate health care, but the other \$5 was extra expenses to that company because of the malpractice event, I suppose you could make an argument then that Blue Cross ought to get the first \$5 because that was a normal expenditure, but when they are asked to pay the second \$5—

Mr. SCOTT. We are talking about the damages, medical damages admitted into evidence that are caused, \$10 damage was caused by the malpractice.

Dr. KELLER. Right.

Mr. SCOTT. Medical expense, Blue Cross/Blue Shield paid it because it was a medical expense. Now, you got a recovery and the question is, should the defendant still have to pay the \$10 or does Blue Cross/Blue Shield get its money back?

We have apparently ruled out the idea that the plaintiff ought to get benefit of the premium in this situation, so if the plaintiff isn't going to get it, should the tortfeasor benefit from the plaintiff's insurance premiums or should Blue Cross/Blue Shield not have to pay the bill?

Which is most appropriate to get the windfall of the collateral source rule situation?

Dr. KELLER. I don't have a firm opinion on that part.

Mr. SCOTT. Don't you agree that the tortfeasor, which in this case, is medical malpractice, in another case, might be a drunk driver, ought to be the last person to benefit?

Dr. KELLER. Yes.

Mr. SCOTT. OK. So if we are going to deny the plaintiff the basis of the benefit of their recovery, then we ought to have subrogation so Blue Cross/Blue Shield gets its money back.

Dr. KELLER. I would agree with that.

Mr. SCOTT. That would be the next fairest thing.

Dr. KELLER. That is right.

Mr. SCOTT. Now, we get back to what effect this has on malpractice. If we deny the plaintiff \$10 and the defendant is going to pay the \$10 one way or the other, the question is does the insurance company gets its money back. How does that reduce malpractice costs?

It doesn't because the doctor's going to pay the \$10 one way or the other. Isn't that right?

Dr. KELLER. If it gets paid twice, then it increases health care—

Mr. SCOTT. The question is whether Blue Cross/Blue Shield is going to have subrogation. I think you agreed that that is more appropriate than having the tortfeasor benefit by the change in the collateral source rule. The doctor is going to pay \$10 one way or the other, right?

Mr. CORBOY. Seems simple to me.

Mr. SCOTT. So it doesn't reduce your malpractice costs? So the only way the collateral source rule change can affect malpractice is if you give the tortfeasor the benefit of the plaintiff's premium.

So if you have two plaintiffs, one with insurance and one not, the insurance company, and we denied that the plaintiff isn't going to benefit, the insured plaintiff isn't going to benefit by its policy, and we agree that if you are going to deny the plaintiff the benefit, Blue Cross/Blue Shield ought not have to pay, the doctor is going to pay the same amount either way if you go into a subrogation situation.

So changing the collateral source rule will not reduce malpractice costs. All right.

Let me get to attorneys' fees. There is a provision in the bill that provides for a certificate of merit. Don't you feel that as a lawyer who is on a contingent fee and if it is not a good claim, I am not going to get paid and probably won't get my out-of-pocket expenses paid, don't you think that is a certificate of merit?

Dr. KELLER. I will answer from the commission's point of view. We do not favor the certificate of merit idea at the present time because we don't think we know enough about it. It is one of those areas that one might explore but there are some real problems, as you point out, one of them being to have people who can make judgments on those cases frequently without adequate information because these would be developed very early in the process of litigation so that all of the facts and all the information that one might need to make a—

Mr. SCOTT. Is there any concern about the certificate of merit, whether it is in there or not? Is it going to make any difference?

[No. response.]

Mr. SCOTT. OK. On attorneys' fees, we are talking about limiting plaintiffs' attorneys fees, and I think Dr. Falcon mentioned one case where it sounded like about 60 percent of the award went to the plaintiff's attorney. Is that—

Dr. FALCON. Yes, sir, it was actually more than that.

Mr. SCOTT. More than 60 percent. OK, if we are talking about reducing the cost of malpractice, how much difference would it have made to the cost of malpractice if the attorney hadn't been paid at all?

Dr. FALCON. That is not the point, sir. The point is that we want more of the malpractice premium going to the injured patient.

Mr. SCOTT. That is fine, but if the fact is that the plaintiff is paying the attorney's fees out of that portion, I think the number you gave was about \$260,000 payment from the defense side to the plaintiff's side, and the criticism was that the plaintiff's lawyer got a disproportionate share of that award.

Dr. FALCON. That is correct.

Mr. SCOTT. If the lawyer hadn't gotten anything, how would that have reduced your malpractice costs?

Dr. FALCON. It wouldn't have, but that was not the issue.

Mr. SCOTT. Let me get to this. Reducing attorney's fees will not reduce the costs of malpractice.

Dr. FALCON. In this particular—I guess your—yes, I would have to agree with you.

Mr. SCOTT. Anybody disagree with that? OK. Periodic payments, I think we all know that if you have periodic payments, the amount of money is paid out over time—the Virginia lottery, when they give out one of these \$1 million, \$50,000 a year for so many years, what they do is buy an annuity on the spot. They buy it for about 50 cents on the dollar and it pays out the \$1 million over 20 years.

Mr. Corboy mentioned the fact that if you have already reduced it to present value, cutting it again by spending it out over time only takes the same discount twice. Do any of the physicians have any dispute with that logic?

Dr. HANNAN. The only other factor to consider is the survival of the patient well beyond what the projection is, or short of what the projection is.

Mr. SCOTT. Doesn't that work both ways?

Dr. HANNAN. Yes.

Mr. SCOTT. I mean, if they live longer, the damage might have been more.

Dr. HANNAN. But if the reward is for a certain period of time and the victim doesn't survive that long, then there is no need for those damages to be paid if it is done over a periodic payment.

Mr. SCOTT. Because you do life expectancy. If they live longer than life expectancy, they didn't get paid enough. If they lived shorter than life expectancy, they got paid too much.

So on judgment day, you take your best shot and that is what you get. I think what you are talking about is if they don't live long enough, then they get cut short. But if they live longer, they don't get any more.

Dr. HANNAN. Right.

Mr. SCOTT. So you want it both ways. Did you have a—

Mr. KEENER. Yes, Congressman. There are really two survivals that we need to be concerned about there. What if the insurance company or annuity company doesn't survive but the patient does. The patient has a verdict he has been told he is going to collect the judgment over time.

The patient might survive but if the insurance company isn't around, then the patient really turns out to be the loser.

Mr. CORBOY. Congressman, may I give you some information on that? Since 1985, the State of Illinois has had a periodic payment

of judgments act applicable to medical malpractice cases at the option of either the plaintiff or the defendant.

Since 1985, not one doctor in the State of Illinois has opted for periodic payments. Why? Because the verdict is not reduced originally. Therefore, let's assume there is a future of \$1 million for medical payments that are necessary for the care of the patient, if those million dollars are not reduced, say, to \$300,000, the verdict is going to be \$1 million instead of \$300,000.

Therefore, doctors and other health care providers do not want that \$1 million verdict against them. They would rather take their chances and take the \$240,000 verdict and have it paid out in one lump sum, if at all.

If I could follow through what I said before. If there is \$1 million of future expenses and it is reduced to \$240,000 and then reduced again, you can see the immeasurable unfairness of the periodic payment of judgments.

The American Bar Association has come out very strongly in favor of periodic settlement, but that is an entirely different matter. That is a matter of negotiation and that is a matter of protecting the plaintiff with a triple A insurance company which does not always follow, by the way.

Mr. SCOTT. So in your case that you mentioned, if you calculated the damages to be \$50,000 a year for 20 years, \$1 million, present value, maybe \$500,000, the physician would have a choice, he could pay the \$1 million over time or \$500,000 lump sum.

What the bill does is—tends to reduce it to \$500,000 and then spread it over the 20 years which has a present value of \$250,000.

Mr. CORBOY. That is right, sir.

Mr. SCOTT. And any periodic payment that doesn't cut it just once, it tries to cut it twice, is unfair.

Mr. CORBOY. And by the way—

Mr. SCOTT. Do any of the physicians disagree with that? Okay.

[No response.]

Mr. SCOTT. OK.

Mr. CORBOY. By the way, when we use the term physician, don't forget we are talking about the insurance company, not the doctor.

Mr. SCOTT. We are talking about all we have here. Let me just say one other thing, and that is that we did a little insurance reform in Virginia and one of the pieces of evidence that came out was that every year for every dollar that comes into the medical malpractice carrier, only about 14 cents went out in claims expenses.

Is that consistent with what people on the panel have heard?

Mr. CORBOY. The figure I heard is last year they collected \$9 billion in premiums, and I may be wrong on this and I will try to get the exact figure, but it was between \$2.5 and \$2.7, I believe it was, in payment of medical malpractice claims.

That is by claims, judgments, satisfactory judgments, settlements, so a little over \$6 billion goes for expenses and also, of course, for financing future litigation and future settlements.

How much of that \$2.5 billion that they pay out is compared to the money they take in, I think, is probably more, and I reluctantly state this to you, is probably more than the 14 cent ratio that you mentioned.

Mr. SCOTT. But it may be as much as 33 cents?

Mr. CORBOY. Yes, sir.

Mr. SCOTT. Any question about that? [No response.]

It seems to me that a little insurance reform would go a lot further than some of the recommendations in the bill.

Dr. Hannan.

Dr. HANNAN. Yes, sir. The thing to keep in mind is that both the incidence of suits and the judgment amounts are increasing as time goes on, so the insurance companies are holding in reserve an amount in excess of what they are paying out this particular year. The cases that were judged this year may go back 10, 12, 14 years.

Mr. SCOTT. Well, we have also heard that fluctuations in medical malpractice premiums are more a function of the interest rates than—as much interest rates as the amount of money paid out in claims.

Anybody want to comment on that?

Dr. FALCON. Mr. Scott, I just wanted to comment that in Texas, we have a 21-year statute of limitation on newborns and so part of that money is also, I guess, going to—for future or possible future lawsuits.

Dr. KELLER. I think that the amount of money going to plaintiffs is much less—that the ratio is much different. The company that I am familiar with has an expense ratio of about 14 percent.

That is what it costs to run the company, if you will. But that does not include when a case goes to litigation and there is a settlement of one sort or another. It does not include all of the fees that are paid to attorneys, both by the plaintiff, who must pay whatever fee there is, plus what the company must pay for their own attorney.

So that the total amount of money getting to plaintiffs is considerably less.

Mr. SCOTT. What effect the plaintiff's attorneys' fees have on the cost of malpractice.

Thank you very much, Mr. Chairman.

Mr. CONYERS. You are welcome. This has been a very interesting hearing. I want to commend Mr. Corboy of the Committee on Medical Professional Liability, Mr. Keener of the American Board of Trial Advocates, Ms. Wittkin of the National Center for Patients' Rights, Dr. Falcon of the Health Care Liability Alliance, Dr. Keller of the Physician Payment Review Commission, and Dr. Hannan of the Medical Society of New York.

You have been very, very helpful. We could go further, but you have been here a very long time. Without objection, I would like the closing statement of Chairman Brooks to be incorporated into the record at this point.

[The closing statement of Mr. Brooks follows:]

I would like to thank the witnesses for their information testimony.

While it is important that the law be fair in the responsibilities it imposes on health care providers, it is also important that our legal system offer fair protections to people whose lives are disrupted by injuries caused by medical malpractice. We must not neglect these important principles as we move into the final stages of the health care debate.

Mr. CONYERS. The hearing is adjourned. Thank you.

[Whereupon, at 1:05 p.m., the subcommittee adjourned.]

APPENDIX 1. MATERIAL SUBMITTED WITH THE PREPARED STATEMENT
OF ANTONIO FALCON, M.D.

Appendix B

PHYSICIAN
PAYMENT REVIEW
COMMISSION

Annual Report
to Congress

1994

MEDICAL MALPRACTICE REFORM

The medical malpractice system does not adequately prevent medical injuries or compensate injured patients. There is also widespread concern that the current functioning of the malpractice system may promote the practice of defensive medicine and impede efforts to improve the appropriateness and cost effectiveness of care. The importance of malpractice reform is underscored by its inclusion in nearly all the major health system reform proposals being considered by the Congress.

This chapter incorporates the Commission's prior work on malpractice reform and extends its recommendations to address additional issues that have been raised in the various health system reform proposals now being debated. These include newly proposed tort reforms, the use of practice guidelines in malpractice litigation, and public disclosure of information about malpractice payments.

RECOMMENDATIONS

The Congress should effect the widespread adoption of certain tort reforms, including:

- **reasonable schedules for noneconomic damages (interim limits may be employed until a schedule is adopted), offset of awards for collateral source payments, periodic payment of large awards, and diversion of punitive damages awards to quality improvement activities;**
- **schedules for attorneys' contingency fees, thresholds for joint and several liability, and reduction to a reasonable period of long statutes of limitations for minors; and**
- **encouragement of the use of binding alternative dispute resolution methods (nonbinding alternative dispute resolution should not be required).**

Although initiatives to require certificates of merit, accord special legal status to practice guidelines, and raise the burden of proof for punitive damages have the potential to improve the functioning of the malpractice system, current knowledge of their effectiveness is not sufficient to justify that they be federally mandated.

Work should begin to develop a future malpractice system that would include a fast, efficient administrative system to compensate patients and a complementary system to detect and prevent medical injuries. To this end, the Congress should provide support for demonstrations and evaluations of binding alternative dispute resolution systems, enterprise liability, and alternative standards of compensability including no-fault. The federal government should support efforts to reduce injuries related to medical care.

Information in the National Practitioner Data Bank should not be disclosed to the public because of the likely adverse effects on the detection, compensation, and prevention of injuries and on disciplinary actions against physicians. Information on preventable injuries and malpractice payments should not be included in health plan performance reports for consumers unless better data and measures of comparability are available.

THE TASK FOR REFORM

The Commission described the goals and problems of the malpractice system in depth in its *Annual Report to Congress 1991* (PPRC 1991). Reducing the rate of medical injury is the most important goal of the malpractice system. Although medical care in the United States is generally of high quality, the incidence of preventable medical injury is more than acceptable. A second goal is to compensate fairly those patients who experience a medical injury. Few patients are being compensated today, and the awards are variable. Besides failing to meet these goals, the existing malpractice system may promote the practice of defensive medicine and impede efforts to improve the cost effectiveness of care. Further, the system's inefficiency results in high administrative costs and long delays in claims resolution. Correction of these deficiencies, then, is the challenge of reform efforts. Malpractice reform must be informed by an understanding of their underlying causes.

The ability of the current system to reduce the number of injuries is limited by its failure to collect and systematically analyze data with which to design and implement measures to prevent medical injuries. At present, most injuries do not result in claims, and databases are largely fragmented. Knowledge about the causes and prevention of medical injury is scarce. In addition, incentives for practitioners, institutions, and health care organizations to participate in formal injury reduction efforts are not as effective as they should be.

Compensation for negligent injuries is not consistent, timely, or proportionate to losses. Nor is it available to all who may qualify. The accuracy of determinations of liability is impaired by the difficulty of applying the negligence standard to individual cases. Awards for noneconomic damages, in particular, are highly subjective and variable.

The provision of cost-effective care may be deterred to the extent that the malpractice system requires (or is perceived as requiring) the delivery of more expensive care than would be

desired by those ultimately bearing its costs. The resulting costs may be hidden to the extent that the standard of care inherent in medical notions of good practice is too high. The legal standard of care results from ad hoc decisions of juries, the retrospective opinions of expert witnesses, and professional practices that may be influenced by other incentives to increase the delivery of services. Paradoxically, health care practices are driven by perceptions of possible legal liability. There is great concern that liability considerations may hinder efforts to reduce the delivery of inefficient or ineffective care. This concern is behind proposals to provide special legal protection for following practice guidelines.

Defensive medicine represents unnecessary or inefficient care delivered to reduce the risk of being sued or paying damages. Its extent and cost are unknown but may be substantial. Several factors may contribute to defensive medicine. The negligence standard does not provide a good prospective guide to decisionmaking. Physicians often disagree about the required standard of care in particular cases (Brennan et al. 1989). Furthermore, judgments of negligence after an injury are biased by knowledge of the adverse outcome, so what may seem to be appropriate care before the fact may later be deemed negligent (Caplan et al. 1991). In addition, physicians probably apply the standard differently than do juries. Judgments of liability that are inconsistent across similar cases, made by lay juries meeting one time, may contribute to defensive medicine. The medical profession's lack of agreement about what care is effective, as well as misperceptions of physicians about the legal standard of care, are also contributors.

The high administrative costs of the current malpractice system result from the formal processes for discovery of information, preparation for and conduct of the trial itself, and the use of expert witnesses. These reflect the need for extensive information and understanding that is associated with an inquiry into medical causation and individual fault. High procedural costs are barriers to filing claims for many potentially compensable injuries, particularly those that are less serious or that entail relatively minor economic losses.

TOWARD A MALPRACTICE SYSTEM OF THE FUTURE

The problems with the malpractice system are so pervasive that only a profoundly different system offers the potential for dramatic improvement. A proven model for such a system does not exist in the United States, but a possible future system is outlined here. The system would have two components. One would be a fast, efficient administrative compensation mechanism that would provide adequate awards to patients who experience preventable medical injuries. The other would be a complementary system for monitoring, quality review, and design and implementation of measures to reduce the rate of injury. Self-insurance or experience rating would provide strong incentives to prevent injuries. An important feature of the proposed system is that decisions about compensation and quality of care in individual cases would each be made by a process designed specifically for that purpose. Clear criteria for compensability and for damages awards would be established.

whereas judgments about quality of care would be made in forums better suited to make those determinations.

The administrative compensation system would provide access for as many valid claims as qualify, yet control the compensation levels to keep the system affordable. Enhanced access would be achieved by lowering economic and other barriers to filing claims, ensuring legal representation, and helping patients realize when they have experienced a potentially compensable injury. Injuries would also be detected by data-based surveillance and by encouraging or requiring the participation of providers in identifying and reporting potential injuries. Nonmeritorious claims would be screened out early, and the overall process would be expedited and efficient. It is possible that an even simpler, less formal process could be instituted for smaller claims. Compensation would be based on a more reliable standard than negligence, such as avoidability of the injury or no-fault.

The injury prevention and quality improvement system would receive information from the compensation system, its own surveillance mechanisms, and voluntary reporting. It would collect and analyze data on injuries, thereby facilitating the design and implementation of interventions. Health care organizations would be self-insured or malpractice insurance premiums would be experience-rated to provide strong incentives to prevent injuries. Ideally, this system would be part of a broader continuous quality improvement system operating throughout the health care system. The system would have an appropriate balance of public and professional input.

To realize this system will entail considerable developmental work; even then, it may not be feasible as described. Its components could, however, be developed in an evolutionary manner and implemented one at a time. To pave the way for this system of the future, the Commission's recommendations focus on:

- improving the functioning of the current system,
- developing and using efficient alternative dispute resolution systems for compensating injured patients,
- formulating and testing more reliable standards for compensation decisions, and
- collecting better data on medical injuries and improving systems to prevent injuries and improve quality of care.

The federal government should play a role in all four of these areas.

IMPROVING THE FUNCTIONING OF THE CURRENT SYSTEM

This section analyzes proposals to improve the performance of the current malpractice system, including various tort reforms, according special legal status to practice guidelines, and enterprise liability.

Tort Reforms

Tort reforms are changes in the legal rules governing malpractice lawsuits. They compose the bulk of the malpractice reforms commonly proposed. Widespread implementation of tort reforms would not in itself solve many of the underlying problems of the malpractice system, which persist even in states that have already adopted many tort reforms. Some tort reforms, however, could help the malpractice system operate somewhat more efficiently and consistently until more fundamental changes are made, and they can be instituted immediately. In the short run, these changes would be beneficial for the health care system as a whole. In addition, some tort reforms are prerequisites for the malpractice system of the future outlined in this chapter.

Tort reforms have been enacted inconsistently by the states. It is unlikely that they will be adopted uniformly, and some have been declared unconstitutional by state courts. For tort reforms to be implemented across-the-board, either federal preemption of state law is required, or states need strong federal incentives to adopt the reforms. A third alternative is to authorize individuals or groups to agree by contract with physicians or health care organizations to adopt whichever set of reforms is mutually acceptable (Havighurst 1989). This, however, would not ensure the widespread implementation of tort reforms. The Commission believes the case for certain tort reforms is sufficiently compelling that they should be federally mandated.

If tort reforms were enacted in isolation, however, their benefits would come at the expense of some injured patients. Some awards would be reduced, and access to legal representation for some potential claimants may be hindered if strict limits on damages and contingency fees were adopted. Ideally, tort reforms should be adopted as part of a broader reform package that includes expanded access to well-functioning alternative compensation mechanisms, better systems to prevent injuries and improve quality of care, or other measures that would benefit patients.

The Commission favors certain tort reforms in conjunction with other reforms that would benefit patients. The following discussion analyzes the merits of proposed tort reforms. If they are adopted, it would be important for the Agency for Health Care Policy and Research to fund studies of the effects of the reforms on patients' rate of claims, access to legal representation, and compensation for injuries.

Schedules for Noneconomic Damages. Much of the unpredictability and inconsistency that characterize today's malpractice awards is because of noneconomic damages (i.e., pain

and suffering), which account for about 50 percent of total payments (Metzloff 1991). Such damages are highly subjective. Reducing this unpredictability and eliminating the potential for unreasonably high awards would improve decisionmaking during the course of a lawsuit and promote settlement. Almost half the states have no statutory limits on noneconomic damages.

Awards for noneconomic damages should be rationalized by reasonable schedules of awards for noneconomic damages. The schedules would set acceptable ranges for awards for carefully defined categories of injuries. Schedules establish a different limit for each grade of injuries, which is preferable to a single absolute limit that may be too high for some injuries and too low for others. Until a schedule is developed, however, it may be necessary to adopt a single interim absolute limit on noneconomic damages.

Schedules for Attorneys' Contingency Fees. The typical contingency fee paid to the claimant's attorney out of an award is about one-third of the recovery. Contingency fees are limited so that they better approximate the fee to the work performed by the lawyer. About half the states have restricted contingency fees in some manner, including 11 that have enacted specific fee schedules or sliding scales based on the recovery amount. Fee reductions possibly may restrict access to legal representation for those with small claims or uncertain chances for recovery, although this problem could be minimized if the schedule permits greater percentages for smaller awards. In addition, it is desirable to discourage those claims that have little chance of success but are pursued simply because the potential attorney's fee is unreasonably large. The Commission recommends reasonable schedules for attorneys' fees so that more of a large award goes to the patient.

Modification of the Collateral Source Rule. The collateral source rule prohibits the consideration of other payments, such as those from health or disability insurance, received by a claimant for losses due to an injury. These sources of payment tend to operate more efficiently than the malpractice system, permitting more money to be devoted to compensation and less to administrative costs. Nearly half the states have not modified the collateral source rule and permit duplicate payments for a given loss. An offset of malpractice awards for collateral source payments is consistent with the compensation function of the malpractice system (although in theory it weakens general deterrence of injuries because the provider does not bear their full cost). Offsets of awards for collateral source payments are advisable under the present malpractice system. They would be vital to the affordability of the internal costs of a future, more-inclusive administrative system for compensating medical injuries.

Restrictions on Joint and Several Liability. In cases with more than one defendant, the doctrine of joint and several liability holds any defendant responsible for the full award if any other defendants cannot pay their shares apportioned by fault. This rule is designed to ensure adequate compensation for the injury, even though it penalizes defendants who have to pay more than what would be warranted by their share of fault. A total of 31 states have placed

restrictions on joint and several liability. Some have adopted a threshold of degree of fault below which joint and several liability does not apply; others have abolished joint and several liability entirely for noneconomic damages.

Practitioners and entities with adequate insurance or resources to pay malpractice awards do not want to pay the full amount of an award when their contribution to fault is minor or negligible. But it should be recognized that limits on their liability may come at the expense of adequately compensating injured patients. The Commission recommends that a balance be struck by adopting thresholds for the application of joint and several liability.

Periodic Payments of Large Awards. More than half the states require that larger awards be paid in installments over time. It is best if the payments are tailored to meet specific future needs. An annuity can be purchased to meet continuing needs resulting from permanent injuries. Annuities also permit tax-advantaged investment of an award. Overall, the Commission considers periodic payment beneficial.

Reductions in Statutes of Limitation. These laws limit the time period, after an injury is or should have been discovered, during which claimants may file a lawsuit. If the allotted period expires, a claim is barred even if it clearly has merit. Most states allow a longer period for minors, often until the age of majority. Long statutes of limitation create uncertainty, delay, and expense in insuring against malpractice claims. Birth-related injuries are the principal source of problems. Eight years is a safe period to allow detection of perinatal injury, and shorter periods are defensible.¹ States that have longer statutes of limitations for minors should be required to reduce them to eight years at most.

Punitive Damages. Punitive damages are rarely justified in medical malpractice cases. They are requested far more often than they are awarded (Metzloff 1991). Judges frequently reduce excessive or unjustified punitive damages awards. Overall, punitive damages do not appear to be an important problem in medical malpractice cases.

Two reforms have been advocated with respect to punitive damages. The first is that part or all of punitive damages awards be diverted to quality improvement activities. The rationale for this is that punitive damages, by definition, are not compensatory in nature. They are not "needed" by the plaintiff. Their purpose is to deter others from similar conduct, thus protecting future patients from injury. Consistent with this rationale would be to use the money from these awards directly for injury prevention or quality improvement activities. The Commission encourages the diversion of some or all of punitive damages awards for these purposes.² Plaintiffs would continue to allege punitive damages when warranted—

¹ Cerebral palsy can usually be diagnosed by three years of age; difficult cases can be diagnosed by the age of five (Stanley and Watson 1985).

² Juries should not be informed of this diversion so that their decisions on damages are not distorted.

despite the diversion—because their expected value would be included in settlement negotiations.

A second proposal for punitive damages is to raise the standard of proof required to receive them, from a preponderance of the evidence to clear and convincing evidence. The argument for this is that the greater penalties represented by punitive damages should be meted out only if proof is more certain than is required for ordinary negligence. This plausible rationale applies to punitive damages in all contexts, not just medical malpractice. Although changing the standard of proof seems reasonable, the Commission believes that the case for this more fundamental change in legal rules should be made on a broader basis than medical malpractice. Alternatively, convincing evidence should be put forward that there is a special need for this reform in the medical malpractice arena.

Certificate of Merit. A certificate of merit is a requirement that an independent medical expert review the medical record and certify that a claim is worthy before a formal lawsuit can be filed. Although this requirement appears reasonable, there are potential problems with it. It adds another step to the litigation process, consuming time and money. This may be a barrier to some meritorious claims that would otherwise be brought. Plaintiffs' lawyers tend to require the plaintiffs to pay for this initial expert evaluation, which is difficult for low-income plaintiffs who already sue less frequently than wealthier ones.

It is often difficult to judge at a case's inception whether it is likely to be successful, because key information is not available in the medical record and must be obtained through the legal process. If the certificate of merit requirement is too strict, some cases that eventually would be successful might be screened out simply because of incomplete information. The test should not be whether the claim is likely to succeed. Rather, the criterion should be some minimum threshold of the probability of success. It may be difficult to develop criteria that would not squelch meritorious claims, yet be strict enough to reduce significantly the number of nonmeritorious claims that proceed to litigation.

Completely frivolous lawsuits do not appear, anecdotally, to be a major problem for defendants, and the defense can fairly easily identify groundless claims. Although the idea has promise, more needs to be learned about the benefits and drawbacks of certificate of merit programs before they warrant being federally mandated.³

Practice Guidelines and Malpractice Litigation

With practice guidelines becoming more integrated into medical practice, more attention is being focused on their relationship to the malpractice system. There are two areas of interest.

³ The certificate of merit requirement proposed in the Administration's health reform proposal would apply only after a claim has been litigated to a final conclusion in an alternative dispute resolution program. It is extremely unlikely that such a claim would be filed anew in the court system unless at least one expert was willing to testify for the plaintiff. The certificate of merit requirement in this context seems superfluous. Procedures to screen out frivolous claims are most useful at the outset of a claim, not after it has already been extensively litigated.

One is whether the system impedes the use of practice guidelines by health care providers to improve the appropriateness and cost effectiveness of care. Another is the effects that practice guidelines have on the process and outcomes of malpractice litigation. This section analyzes these topics and describes the results of a Commission-sponsored study of the use of practice guidelines in malpractice litigation.

The Relationship of Practice Guidelines and the Malpractice System. The treatment of practice guidelines in the malpractice system has important implications for their success in promoting the delivery of appropriate, cost-effective care. Practice guidelines could provide an important legal support for physicians and health care organizations that use them to provide less-costly but appropriate care. But revisions of practice guidelines by the judicial system could render practice guidelines ineffective in helping to control costs and improve quality. Such revisions could take two forms: an explicit rejection of the content of the guideline, or a carving-out of exceptions that effectively vitiates it. In response to this concern, states are providing or planning to provide special legal status to practice guidelines to facilitate their use by defense attorneys, and thus encourage their use by physicians (General Accounting Office 1993).

Practice guidelines may help to improve the functioning of the malpractice system (Garnick et al. 1991). This is because guidelines can make clear the applicable standard of care, which is a troublesome issue in many malpractice cases. They might also lessen the need for expert testimony on the standard of care, thus avoiding a battle of the experts. Guidelines may appropriately increase the amount of malpractice litigation by helping make clear to injured patients, their lawyers, or juries that a standard of care was breached. But several factors might prevent any improvement in the malpractice system resulting from the use of practice guidelines. The topics on which guidelines are being developed probably are irrelevant to the circumstances leading to most malpractice claims. Guidelines might be revised or reversed by the judicial system, either explicitly or by the creation of exceptions. In addition, increased litigation might result from questioning the validity of guidelines or the circumstances under which exceptions are warranted. Further, guidelines might be construed to create a firm standard of care when one is neither intended nor appropriate. Finally, the need for expert testimony might stay the same or even be increased.

The Harvard Study. Because little is known about the use of practice guidelines in malpractice litigation, the Commission engaged Harvard University researchers to conduct a study to provide empirical information on this topic (Hyams et al. 1994). The study had three components. The first was a review of published judicial decisions that concern practice guidelines. The second was a review of malpractice claims files to determine how often guidelines were used in actual malpractice cases, and to discover the ways they were used. The last was a survey mailed to a sample of plaintiffs' and defendants' lawyers.

A computerized search of all published judicial decisions located 32 cases in which practice guidelines were used: 23 by the plaintiff (claimant) and 9 by the defendant. Plaintiffs won 17

of the 23 cases in which their lawyers used the practice guideline, while in 6 of 9 cases a practice guideline was used successfully by the defense. Five additional cases concerned the narrower question of whether national practice guidelines could provide evidence of local standards of practice. The majority of the cases involved practice guidelines promulgated by the American College of Obstetricians and Gynecologists.

The claims files of two malpractice insurance companies were randomly sampled (with oversampling of anesthesia and obstetric claims) and 259 claims were reviewed. Only 17 (7 percent) involved the use of practice guidelines, 11 of which were obstetric cases. In 12 of the cases the practice guidelines were introduced by the plaintiff's lawyer, and in 4 they were used by the defense (one case was indeterminate). Although the power of the analysis was limited by the small numbers, the use of guidelines was not significantly associated with various characteristics of the physician, lawyer, hospital, or injury, except that physicians who had a longer relationship with the patient were significantly more likely to have claims that involved practice guidelines than were others. There seemed to be greater use of guidelines in cases involving nonteaching and smaller hospitals, as well as those filed by Medicaid patients.

Surveys were mailed to a random sample of 960 plaintiff and defense medical malpractice attorneys in the United States; 578 (60 percent) responded. Three-quarters were aware of practice guidelines. Half the respondents had at least one case each year in which guidelines played a role, and a high proportion reported that the use of guidelines was increasing. The majority of the cases involved care that departed from the guideline. While most of the attorneys reported that the need for experts in the practice guideline cases had not changed, 5 percent of attorneys said it had decreased, and 12 percent said it had increased. Of the attorneys representing plaintiffs, one-quarter stated that a guideline had influenced their decision not to take a case in the past year; one-quarter of all the attorneys noted that a guideline had influenced their decision to drop or settle a case. Finally, one-quarter also said that a guideline had influenced the decision of a trier of fact (jury or judge) in at least one case during the preceding year.

Several conclusions can be drawn from this study. Practice guidelines are playing a modest but increasing role in malpractice litigation. Obstetric guidelines are most frequently being used, probably because they are among the oldest and best known to physicians and lawyers. Guidelines are being introduced more often by plaintiff than by defense attorneys, possibly because guidelines may provide cheaper or stronger evidence of the standard of care than expert testimony. The use of guidelines by either side is usually, but not always, successful in malpractice litigation.

Although the effects of guidelines on the litigation process are varied, overall they seem positive. Guidelines helped judges and juries reach decisions, but there was not much change in the need for expert testimony. Even though the overall effect of guidelines on the amount of litigation cannot be assessed, they may well have led to better decisions to take, settle, or

drop cases. Future monitoring and research are needed to assess whether guidelines are being used appropriately in court, including whether disputes about their applicability or content are troublesome. The results should inform how guidelines are derived and created. Some states have given guidelines special legal status in malpractice cases. Their experience should be assessed, paying particular attention to whether these actions have promoted or impeded the appropriate use of guidelines in litigation and in patient care.

Enterprise Liability

Enterprise liability refers to the situation when a health care organization assumes financial responsibility for all negligent injuries to patients under its care, thereby relieving individual practitioners of all personal tort liability for such injuries (Weiler 1991). This is thought to offer two benefits. First, enterprise liability results in clear savings in administrative costs. Instead of multiple defendants—each often requiring separate lawyers and investigations—there is only one defendant: the enterprise. Additional savings also result from eliminating the many separate individual and corporate malpractice insurance policies that must otherwise be maintained.

Second, enterprise liability is thought likely to result in fewer medical injuries. It places the burden of injury detection and prevention on an entire entity or system that delivers care, one that can more effectively use resources—and devote more resources—to accomplish these tasks than individual physicians acting separately. Others argue, however, that enterprise liability deprives individual physicians of the deterrence incentive stemming from their need to purchase their own malpractice insurance. The debate is theoretical because of the absence of empirical evidence relevant to the issue.

The formation of accountable health plans under system reform would undoubtedly accelerate the trend toward integrated delivery systems and other entities that increasingly look like unified enterprises. Enterprise liability already exists for hospitals owned and staffed by one organization, such as a health maintenance organization (HMO), or a typical university or county hospital, and for those that provide, or channel, malpractice insurance to their affiliated staff. As vertical integration spreads through the delivery system, enterprise liability is likely to follow for reasons of efficiency. Enterprise liability is also the end result of the trend in legal doctrine toward holding hospitals and other health care organizations responsible for negligent injuries to patients (Weiler 1991).

Enterprise liability is probably an inevitable result of legal trends and the incentives sharpened by increased competition in the medical marketplace. The policy question is whether its spread should be encouraged or required sooner than would occur otherwise. There are some practical difficulties with imposing enterprise liability. It requires an enterprise that is tied financially and professionally to the care for which it is responsible. If a hospital and its medical staff were considered an enterprise, for example, this relationship would be present for inpatient but not outpatient care. Third-party payers are financially but

not professionally linked with physicians, at least at this time. It would also be difficult to calibrate malpractice insurance premiums and fees for physicians who do not practice exclusively within an enterprise.

Several steps could be taken short of imposing enterprise liability. Policymaking would be improved if there were empirical evidence that enterprise liability reduced costs and enhanced quality of care. Federal support is thus warranted for demonstration projects and evaluations of existing examples of enterprise liability.

Another possible step would be to require accountable health plans to report information on aggregate malpractice payments made to their patients for consumers to use in comparing plans. This approach would not involve plans in defending physicians or paying damage awards on their behalf, but it would give plans an incentive to select doctors more carefully, monitor the malpractice claims experience of their physicians, and help them avoid claims. Physicians would have a greater incentive to ensure that their professional colleagues work to prevent negligent injuries. It would be useful to supplement malpractice claims information with a requirement that health plans actively monitor for preventable injuries to their patients as part of their quality assurance activities. For reasons discussed later in this chapter, improvements in data and measures of comparability are needed before this should occur.

Finally, enterprise liability could be encouraged by the way in which quality assurance activities are structured within health plans. Health plans could be required to conduct such activities in a manner analogous to that of hospitals, through the equivalent of medical staff quality assurance committees. Each plan would be responsible for ensuring the successful operation of its committees, but the physicians—the health plan's medical staff—would perform the peer review and quality improvement activities. A group of plans could delegate this function to a single local entity, so that each plan would not need its own quality assurance committee. Quality assurance structures that link physicians and engage them in quality review could pave the way for better quality improvement activities and an easier transition to enterprise liability.

COMPONENTS OF A FUTURE MALPRACTICE SYSTEM

These recommendations would help improve some of the deficiencies of the malpractice system. They would not, however, address two underlying causes of the problems with the malpractice system: reliance on the court system, and use of the negligence standard to determine both the standard of medical care and eligibility for compensation. The future malpractice system envisioned by the Commission would utilize an efficient administrative system to resolve claims on the basis of a standard for compensation that is more reliable than the current negligence standard. Such a system would be helpful for monitoring quality of care and implementing programs to prevent medical injuries.

Alternative Dispute Resolution Systems

Significant improvement in processing malpractice claims can occur only outside the courtroom. Administrative systems and other alternative dispute resolution (ADR) methods offer the potential for resolving malpractice claims more quickly, efficiently, and consistently (Johnson et al. 1989). A variety of ADR mechanisms have been developed, such as arbitration and mediation. Administrative systems not only may give potential claimants easier access to compensation, but also use alternative standards for compensation (discussed in the following section). The future compensation system anticipated by the Commission would rely on an administrative system to process claims. Most malpractice reform proposals encourage or require using alternative dispute resolution.

Several possible features of ADR mechanisms may improve the resolution of malpractice suits. If decisions were made by someone with experience (as could be the case with ADR), they might be of better quality, have more precedent-setting value, and be more consistent. By contrast, a jury meets only once; it has no firsthand experience to draw upon in deciding cases and no access to written decisions for other similar cases. A jury does not have to justify its decision, nor is it accountable for its performance. If decisions were written and accessible, they would likely be more consistent and predictable. Inconsistencies among cases could be resolved by an appeals process, and the relevant standard of practice would then be known prospectively by health care providers. An administrative decisionmaker may be more likely to understand and honor the recommendations of good practice guidelines and to condone cost-effective care.

Little is known about the efficacy of ADR in medical malpractice, although the experience of Kaiser Permanente is helpful. Several of its health plans use mandatory binding arbitration to resolve all malpractice claims. Their experience reportedly has been favorable, in that litigation costs are somewhat less because the hearings are much shorter than those in jury trials. In addition, compared with public trials, private arbitration hearings are less burdensome for Kaiser physicians. Cases appear to be resolved faster than comparable cases litigated in the courts (Felsenthal 1994). Kaiser has discontinued arbitration in at least one region, however, because the quality of the available arbitrators was considered insufficient.

Despite its potential, alternative dispute resolution has a number of possible drawbacks. If the result reached through ADR is not binding, the method would merely impose significant additional delays and costs on an already slow and expensive litigation process. In addition, the constitutional right to a jury trial is a potential barrier to requiring the use of binding ADR. And finally, whether shifting attorneys' fees to the party who loses an appeal in the courts truly discourages resort to the courts is unknown. On the one hand, lower-income claimants might be relatively disadvantaged because attorneys would require them to assume the risk of paying their opponent's legal fees. On the other, the fee-shifting provision might be waived for them, and thus not have its desired effect of discouraging relitigation in the courts. An ideal scenario would be the development of ADR systems advantageous to

plaintiffs and defendants alike, so that both would voluntarily agree to using them and being bound by the result.

One of the judicial system's most important features is its perceived impartiality and the degree of control accorded the parties over the litigation process. This is especially important to injured claimants, who may feel less powerful than the provider or system they are suing. In administrative or ADR systems, the decreased amount of formal procedural protection makes the need for objectivity even more important. Although using experienced personnel can be advantageous, it can be difficult for them to remain unbiased when dealing with a few large repeat players such as malpractice insurers and health plans.

Further, each type of ADR method is more useful in some situations than in others. There is little experience in tailoring the use of ADR to the needs of particular cases. The quality of any ADR process depends heavily on the personnel involved. It is unlikely that enough high-quality ADR services would be available immediately if all medical malpractice cases had to use this technique. Finally, ADR systems may evoke counterproductive behavioral responses, which are difficult to predict in advance. For example, if final adjudicatory hearings are cheaper, easier, and faster than jury trials, more cases might proceed to such hearings, lengthening rather than shortening delays in compensation.

In view of these uncertainties, it may be premature to require that all malpractice claims be resolved through ADR. Demonstrations and evaluations should be supported by the federal government to learn more about how these systems can best operate. Workable methods need to be devised to permit easier access for potential claims while rejecting nonmeritorious claims early. Incentives for settlement should be used. Among the issues that require study are the length of time needed to resolve cases, the system's efficiency and ability to improve access for claims, and the objectivity and quality of the judgments.

Alternative Standards for Compensation

The negligence standard does not appear to be a good guide to decisionmaking by providers and juries. Possibly, more reliable standards for liability could be developed, such as ones based on no-fault or avoidability of the injury. Such standards must be tested for their reliability and their effects on the number and size of claims paid.

No-Fault. A no-fault standard would compensate patients whose injuries were caused by medical care, regardless of whether the care was substandard or not. The determination of eligibility for compensation would be simplified by dispensing with the need to determine the standard of care and whether it was breached. Evidence from one study suggests that judgments of causation can be made more reliably than judgments of negligence, although some difficulties would remain because the adverse effects of treatment must be distinguished from the underlying illness (Brennan et al. 1989). Definitional problems may occur if the

universe of compensable injuries is further limited, such as excluding unavoidable failure or treatment from compensation.

The principal fear raised by a no-fault system is that vastly larger number of injuries might become eligible for compensation. Awards would have to be restricted to keep the system affordable. In estimating the cost of a hypothetical no-fault system in New York, for example, the Harvard Medical Practice Study investigators restricted compensation to net economic losses experienced more than six months after the injury, with no noneconomic damages permitted (Harvard Medical Practice Study 1990). In addition, the experience overseas is that, with a no-fault system, the number of claims increases steadily (Hellner 1985). A no-fault standard should be tested first in a demonstration in the United States. When comparing results across systems of care, demonstrations should employ methods to adjust rates of injuries and levels of compensation for differences in the health systems' patients—especially age—that influence the likelihood and severity of injuries.

Avoidability. Some errors in care are not negligent. For example, a mistake in considered professional judgment is often deemed not to be negligent. Whereas in hindsight an injury might have been avoided, having missed the opportunity to prevent it is not necessarily negligent. It may be easier to determine whether an injury was avoidable—by some measure of probability—than whether failure to avoid it was due to negligence.

A standard based on avoidability is appealing because it compensates patients for injuries that need not have occurred. It also would focus prevention efforts on the full range of preventable injuries. Fewer claims would be compensated than under no-fault, which would help keep the system affordable. For example, a particular treatment may entail a known but unavoidable risk of a serious injury or complication. Patients who experience an adverse outcome from the treatment would be compensated under a no-fault system, but not under a standard based on avoidability. More claims would qualify for compensation, however, under an avoidability standard than under a negligence standard.

An avoidability standard would offer other advantages as well. It shares with no-fault the advantage of not conditioning compensation on a judgment about whether the care was substandard.⁴ Compensation for an injury would not itself mean that the care was negligent; that determination would need to be made through another mechanism. That compensation would not depend on judgments about quality of care could reduce inappropriate defensive medicine practices and improve providers' confidence in the system. At the present time, there is no information on the reliability of such a standard, but it may be more reliable than the negligence standard.

⁴ The accelerated-compensation event proposal attempts to spell out an avoidability standard for certain injuries (Tancredi and Bovbjerg 1991; Bovbjerg et al. 1991). These comprise a list of avoidable adverse outcomes of care that are designated in advance to be compensable. The current malpractice system would continue to govern compensation for all other injuries. An accelerated-compensation event system that applies only to a subset of injuries, however, may generate disputes about which system covers the injury.

BETTER PREVENTION OF MEDICAL INJURIES

The prevention of medical injuries is a difficult task that requires considerable resources and a systematic approach. The general deterrence incentive provided by the threat of legal liability is not sufficient to reduce preventable injuries to a minimum. In part, this is because the general incentive for physicians not to be negligent must be translated by individual physicians into the particular ways in which they try to avoid injury. Isolated lapses in vigilance inevitably happen, and it is difficult for individual physicians to learn from the relatively few occurrences about which they may be aware. In any case, since the general deterrence incentive is already in effect, specific measures designed to prevent injuries are needed to reduce their rate of occurrence further.

A systematic approach to injury prevention is likely to be more effective than relying purely on general deterrence. Risk management activities within hospitals, for example, have been shown to be associated with fewer malpractice claims (Moriocck and Malitz 1991). Effective injury reduction programs require the collection and analysis of data, as well as the design and implementation of effective interventions.

Data Collection

Better data are needed to help detect preventable injuries and determine their causes. Data usable for injury reduction have come principally from closed claims files of malpractice insurers. Only a small percentage of avoidable injuries is included in such files; often, the information about each claim is limited (Harvard Medical Practice Study 1990). There is also a substantial time lag for claims files to accumulate information, since they depend on the legal process. The National Practitioner Data Bank (NPDB) in theory contains a complete listing of malpractice claim payments, but the information on each claim is not coded in a way that is useful for prevention activities.

Early warning systems and active surveillance are needed to detect as many preventable injuries as possible, not just those that result in claims. The basic epidemiology of medical injuries needs to be delineated. Methods to describe the etiology and nature of injuries are in their infancy. Coding systems need to be developed to permit this more abstract information to be entered into computerized databases. Because many events need to be collected and analyzed to detect patterns of rare events, local databases must be compatible to permit merging. Health system reform may provide an opportunity for developing standardized coding and databases (see Chapter 16).

Despite its importance, however, data-based surveillance—no matter how well designed—is not sufficient. The best information source concerning care-related problems is the caregivers themselves. Early warning and reporting systems for medical injury have been effective in identifying, soon after their occurrence, many of the injuries that result in claims (Lindgren et

In 1991,⁵ it is likely that many of the preventable injuries reported by physicians are not discoverable in the medical record simply by using standard screening techniques. Confidential voluntary reporting of potentially preventable injuries to a hospital or other responsible organization has promise (Petersen et al. 1992). Voluntary reporting of injuries, as well as participation in peer review and injury prevention activities using those data, needs to be protected and encouraged by state and federal law.

Design and Implementation of Interventions

When preventable medical injuries are detected and their causes understood, ways must be devised to prevent such occurrences. These interventions can be either cognitive or procedural. The education of providers is important: cognitive interventions make sense intuitively to address cognitive mistakes. Errors that cause injury, however, are often due to isolated lapses that are difficult for individual health care workers to eliminate. In addition, some injuries are caused by problems in health care delivery systems and procedures rather than by an individual caregiver's mistake.

Systems or process interventions are likely to be even more effective at preventing injuries than education alone. Administrative policies and medical practice guidelines can be designed to minimize the risk of avoidable injury, and checks can be instituted to make sure that policies are followed. Guidelines for intraoperative monitoring of blood oxygen saturation, for instance, have reduced the number of hypoxic injuries during anesthesia (Keenan and Boyan 1991).

Integration with Quality Improvement. These activities are best performed in conjunction with the quality assurance and improvement programs of health care organizations. Structures to conduct these functions do not exist for fee-for-service plans. Hospitals are natural locations for surveillance and early warning for inpatient care problems, but outpatient care may be more difficult to monitor. The standardized data reporting that may be required under health system reform, however, could facilitate the detection of preventable injuries stemming from outpatient care (see Chapter 16).

After possible preventable injuries are identified, individual cases must then be reviewed. Some thought is needed on how peer review can be better conducted, especially for outpatient care. As described above, one way in which health plans could conduct better quality assurance and improvement activities might be for the professional staff of a health plan to be responsible for peer review within that plan in the same manner in which the medical staff of a hospital is responsible for quality assurance related to physicians. The health plan would ensure that quality assurance committees and structures exist and are functioning properly.

⁵ There are additional benefits to early identification of patients injured by medical care. Any needed remedial or rehabilitative treatment can be provided sooner. Claims can be resolved earlier. A better, contemporaneous evidentiary record can be created and preserved, which can help improve the accuracy with which liability determinations are made.

but the actual peer review and quality improvement activities would be the responsibility of the physicians participating in the plan. Monitoring and early warning systems would identify problems for review by the quality assurance committees. It may not be necessary for each health plan to maintain an independent committee for local peer review of physicians not tied to a single plan; it may be easier to use a single review organization for multiple payers that is structured on local group practices, hospitals, or geographic areas (see Chapter 10).

The Role of the Federal Government. The federal government should ensure that practitioners, hospitals, and health care organizations engage in effective efforts to reduce injuries due to inpatient and outpatient medical care, including those caused by negligence. These activities should be a required part of quality assurance and improvement programs of practitioners and health care organizations, and should include both inpatient and outpatient care. The federal government should support research on the etiology, classification, and prevention of medical injury. Support should be given to the development of the necessary databases and to efforts to reduce the incidence of medical injury.

Disclosing Information About Malpractice to the Public. One strategy that has been suggested to protect patients from negligent injuries is to provide them with information about the malpractice experience of physicians and health plans. Consumers could be given access to the physician-specific information about malpractice payments contained in the NPDB, to which all malpractice payments made on behalf of physicians must be reported. The NPDB information is now available only on a confidential basis to hospitals and other qualified health care institutions for physicians who have staff privileges or are applying for them. Some managed-competition proposals envision consumers using a quality report for health plans that could include information about the plan's aggregate malpractice experience (see Chapter 10). These possibilities raise difficult issues. Among these are the public's right to information and choice, and the ability of consumers to understand and use primary information relating to quality of care. Others relate to the effects of public disclosure on the processes that generate the information, and whether internal programs or external public pressure is more effective in improving quality (to the extent that the two strategies are incompatible).

Some believe that consumers have a right to the information in the National Practitioner Data Bank to help choose a physician. They argue that fears that the public will not understand or will misuse the information are paternalistic and unfounded. Perhaps implicit in this position is the belief that the oversight mechanisms of the profession and of state licensing boards have not been successful in protecting the public from substandard practitioners.

Other considerations, however, weigh more strongly against permitting public access to the information in the National Practitioner Data Bank. This information essentially comprises profiles of the malpractice experience of each physician. It is subject to the potential problems with profiling information that the Commission has previously discussed, including the accuracy and relevance of the data (PPRC 1992).

The information in the NPDB is probably highly accurate in terms of payments to claimants (although some degree of underreporting undoubtedly occurs), but the brief description of each negligent event often does not permit a full understanding of the circumstances of the injury. Issues of causation and negligence are often quite difficult and complex in individual cases, and it can be problematic to allocate individual responsibility for a medical injury. The relevance of the data is questionable. Paid malpractice claims are only modestly predictive of future claims. This is enough to experience-rate groups of physicians but not sufficient to predict the future experience of any one physician (Roiphe 1991).⁶ A paid malpractice claim does not necessarily represent poor quality of care, and even poor care in any particular instance does not imply incompetence with respect to that condition or procedure. Finally, it would be difficult for consumers to use the data to avoid receiving negligent medical care, because errors or poor competence in one aspect of care are probably not predictive of problems in others (Sanazaro and Worth 1985).

Permitting public access to the NPDB would likely adversely affect the underlying processes that generate the information. There are anecdotal reports that more physicians are refusing to settle cases in order to avoid being reported to the now-confidential NPDB. The allocation of fault among individual physicians involved in a case is problematic and difficult to convey in NPDB reports. The need to assign individual fault and report physicians to the NPDB can cause unnecessary conflicts within enterprises. These effects would be greatly exacerbated if the NPDB were opened to the public. The incidence of defensive medicine, particularly the avoidance of risks by refusal to provide high-risk services, would likely be increased.

These problems would be lessened if aggregate malpractice claims experience, rather than physician-specific information, were reported yearly for health plans. Perhaps this information could be included on the quality performance reports that are part of managed-competition proposals to aid consumers when choosing among plans (see Chapter 10). Individual physicians' behavior would be less likely to be affected, but health plans might become less aggressive in searching for preventable injuries and more interested in prolonging litigation when possible. Before such aggregate malpractice data could be reported, however, appropriate measures must be developed to ensure comparability of the profiles among plans, including the mix of services they provide and the propensities of their enrolled populations to file and resolve claims. With some experience and research, however, meaningful indicators might be developed that would not cause adverse behavioral reactions by plans or practitioners. For example, one possible measure of a plan's performance in detecting negligent injuries might be the number or proportion of injuries that resulted in successful malpractice claims but were not first detected by the plan itself. Most health plans

⁶ The Administration's health reform proposal would limit disclosure to physicians with multiple claims that exceed a threshold to be set by the Secretary of Health and Human Services. Although this would better target physicians more likely to have future malpractice claims, the malpractice risk exposure of the physician must be taken into account. The threshold for disclosure should vary depending on the number of years of practice, whether the physician works full time, the physician's specialty, and the relative risk within that specialty of the services provided by the physician.

do not now have access to information on malpractice claims against physicians or hospitals, so data sources would need to be developed and refined.

Ultimately, decisions concerning public disclosure of information on malpractice claims depend on judgments about whether quality of care in general—and the rate of negligent medical injuries in particular—would be improved and at what cost. At present, the Commission believes that the problems related to public disclosure outweigh the benefits.

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Medical Professional Liability

An Examination of
Claims Frequency and Severity in Texas



Jointly Prepared by
TEXAS MEDICAL ASSOCIATION
and
TONN & ASSOCIATES

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INTRODUCTION

In July of 1992, Tonn and Associates presented a report, "Medical and Hospital Professional Liability", to the Texas Health Policy Task Force which contained a preliminary analysis of medical malpractice claims data through 1990, focusing particularly on the contribution of the current medical malpractice system to the rapid growth of health care expenditures. In order to explore additional issues especially reports of explosive growth in the frequency of physician liability litigation, the Texas Medical Association initiated additional study of the claims frequency and severity for medical professional liability. Toward that end, TMA's Health Care Financing Department obtained and analyzed the complete data base maintained by the Texas State Board of Medical Examiners for claims reported through 1992. Tonn and Associates was retained to assist TMA's staff in analyzing the data in order to validate the methodology and verify the findings.

METHODOLOGY

The State Board of Medical Examiners gathers a comprehensive set of claims data for all licensed physicians in the state. Texas law requires that claims be reported when a physician or his insurer is notified of a claim which "seeks damages relating to the insured's conduct in providing or failing to provide medical or health-care services" (Article 4495b, V.A.C.S., Sec 5.05(a)). A simple request for medical records does not meet this definition. It should be noted that a notice of claim, as defined above, is the event that commonly causes a physician or his insurer to begin preparations for a legal defense by opening an investigation or retaining legal counsel. Therefore, the claims reported to the Board of Medical Examiners comprise an appropriate measure of the impact of medical malpractice claims on physicians.

In analyzing the data, it was possible to isolate three different units of analysis. The file is composed of records of individual claims against physicians, the first level of analysis. In some cases, several claims against physicians may have arisen from the same incident. These claims can be grouped together to represent a plaintiff claim, the second unit of analysis. Finally, it is possible to identify the number of individual physicians who are affected by claims, without regard to the number of claims against each individual. This third unit of analysis is referred to as the "unduplicated physicians receiving claims".

When analyzing the claims data for a specific year or a specific county, it is difficult to fully reconcile all the data. For example, a claim initiated in a specific year and county may involve defendants who practice in more than one county and additional defendants may be named to the same claim in subsequent reporting years. Despite these occasional small discrepancies, the large number of claims provides an indication of trends for both frequency and severity.

MAJOR FINDINGS

Claims frequency has increased at an alarming rate for 1990, 1991, and 1992 on a statewide basis and in many counties. In particular, claims frequency has increased to unprecedented levels in a number of large counties including Hidalgo where in 1992, nearly 3 of every 10 physicians received at least one claim against them. Other counties with high claims frequency included Montgomery, Cameron, Webb, Nueces, Tarrant, Lubbock, Jefferson, Smith, and Harris counties.

Even after adjusting for inflation, there is a significant increase in the total indemnity dollars paid in the early 1990's over the late 1980's for both claims against physicians defendants and plaintiff liability claims.

A large percentage of the claims that are filed result in no indemnity paid by physicians. These claims cause cost to be incurred with no ultimate benefit to plaintiffs.

There is a need to further identify and research the factors causing high claims frequencies. The result of this further research could have implications for:

- public policy affecting the legal and medical framework of medical professional liability in Texas,
- medical school curriculum development,
- physician-patient relations

- alternative dispute resolution, and
- potential for reducing claims by giving providers greater insight into the causes of litigiousness.

FREQUENCY OF CLAIMS

To better assess the trends of claims frequency, claims data were assembled based on claims against individual physicians and claims tied to particular plaintiffs. This is significant since one plaintiff may file a claim against several physicians. Therefore, trends regarding activity in a given area of the state can be examined based on the number of claims against physicians and by the number of plaintiffs initiating a claim.

Even though the exact number of claims may vary due to some reporting differences, the trends attributable to counties with large populations indicate claim frequency has been increasing at a rapid pace during 1991 and 1992.

The Tonn report indicated that claim frequency had increased substantially during the mid 1980's and perhaps was leveling off in 1989 and 1990. However, the 1991 and 1992 data now suggest that the ratio of claims against physicians and the ratio of plaintiff claims to physicians have reached unprecedented levels. Chart 1 reflects the ratios as percentages. The ratios are also presented graphically in Chart 2. The data indicate that even though the number of physicians and the population has been increasing, the ratio of claims, particularly for 1991 and 1992, has still been increasing at an alarming rate. The ratio of plaintiff claims to

physicians in 1988 was 8.2 percent and in 1990 the ratio had actually declined to 8.0 percent. However, as Tonn reported during the presentation of the earlier findings, insurers had raised concerns to him that they were experiencing higher numbers of claims during 1992. In fact, the ratio of plaintiff claims to physicians increased to 9.6 percent in 1991 and to 12.1% in 1992. Chart 3 graphically illustrates the claims activity as reported through 1992.

There have also been questions as to how many different physicians are being affected by professional liability claims. To examine this question, a detailed analysis was conducted to calculate the unduplicated number of physicians receiving claims for counties with population over 100,000. Chart 4 rank orders the counties and indicates that in 1988, for example, 19% of the physicians in Hidalgo county received a claim, in 1990, 21.5% received claims, and in 1992, the percentage had increased to 29.6%. These numbers compared respectively to a statewide average of 10.8 percent, 11.6 percent, and 14.4 percent. These frequency rates and the overall increases represent significant changes. For 21 of the 29 large counties in Texas, the frequency rate increased from 1990 to 1992. Charts 5A, 5B, 5C, and 5D provide additional descriptive data for those same counties for 1992 and are sorted or ranked as noted at the top of each chart. An alphabetical listing of counties is presented in Chart 6 depicting similar data for counties in which claims were filed in 1992.

To examine frequency of claims against physicians by specialty, Chart 7 was prepared comparing 1988, 1990, and 1992. In addition to the large number of claims against plastic surgeons, many other specialty categories have experienced significant increases. Some of these specialties include radiology (25.3% to 49.2%), cardiovascular diseases (19.6% to 28.8%), emergency medicine (18.2% to 24.6%), general surgery (14.0% to 22.3%), Ob/Gyn (20.6% to 26.8%), and oncology (8.37% to 28.2%). Chart 8 presents a similar comparison with an unduplicated number of physicians receiving claims by specialty. It is significant to note that the Texas State Board of Medical Examiners is not requiring full reporting for product liability claims and as a result an accurate accounting for breast implant cases is not reflected in the number of total claims.

SEVERITY OF CLAIMS

Questions of severity continue to be difficult to interpret. The Tonn findings using claims data through 1990 indicated that indemnity payments when adjusted to constant dollars increased in the mid 1980's and appeared to level off in 1989 and 1990. This finding is consistent with national data. As opposed to tracking claims tied to the original date of the claim, the current research was able to tie the amount of the disposition payment to the date of final disposition, independent of the date of the original claim.

Charts 9A, B, and C present an analysis of claims against physicians. Chart 9A presents the data in unadjusted dollar amounts. Chart 9B presents the data in CPI-General Constant dollars. The data presented in CPI-Medical constant dollars (Chart 9C) indicate that the average indemnity payment has remained relatively flat since 1988. The payments at the twenty fifth percentile and the fiftieth percentile (median) have increased. Payment amounts at the seventy fifth and ninety fifth percentile have fluctuated and slightly declined over the same time period. Total dollars paid, however, are up significantly from the late 1980's.

Charts 10A, B, and C compare plaintiff liability claims. Chart 10A presents the data in unadjusted dollar amounts. Chart 10B presents the data in CPI-General

constant dollars. Chart 10C shows that average payments have fluctuated since 1990 while the payments at the twenty fifth, fiftieth, and seventy fifth percentiles have increased. Plaintiff liability claims at the ninety fifth percentile have declined. However, total dollars for plaintiff liability claims have increased significantly from the late 1980's.

RISK IN RELATION TO TIME: THE LONG TAIL

Since 1980, twenty percent of all claims have been filed more than two years after the date of injury. Among the high risk specialties, the percentage of delayed cases is higher for plastic surgeons, most likely the result of a recent surge in breast implant claims, and lower for emergency physicians (Chart 11). Chart 12 illustrates the number of days from incident date to claim filing date for claims filed from 1983 to 1992.

Forty-nine percent of all plaintiff claims reported in 1991 and thirty percent of all plaintiff claims reported in 1990 remained open by August of 1993, and at least six percent of claims against physicians filed in every year since 1980 remain open.

CLAIMS CLOSED WITH NO INDEMNITY PAID

There continue to be many claims reported to the State Board of Medical Examiners that are ultimately closed with no indemnity payments. For claims filed in 1989 which have been closed, seventy-one percent of claims against physicians were closed with no indemnity (Chart 13). In some cases, physicians are named in a claim to protect the claimant and subsequently are dropped as information is developed which indicates that he was not negligently involved. The claims frequency problem continues to concern physicians because of the physician's time and defense costs associated with resolving a claim. When a physician receives a notice letter, it is common for the physician to forward such notice letter to their insurer. When an insurer receives such notice, an investigation and related costs start to be incurred. If the plaintiff's attorney later determines there was no negligence and so advises the claimant, who files no suit, the claim will be reported as having been closed with no indemnity being paid. In addition, parties who are potentially liable are listed as parties to a lawsuit even though they may be dropped from the suit before trial. Physicians and insurers continue to be concerned about the large numbers of such claims being initiated because of the time and costs associated with closing claims even though no indemnity payments are being made.

Chart 1

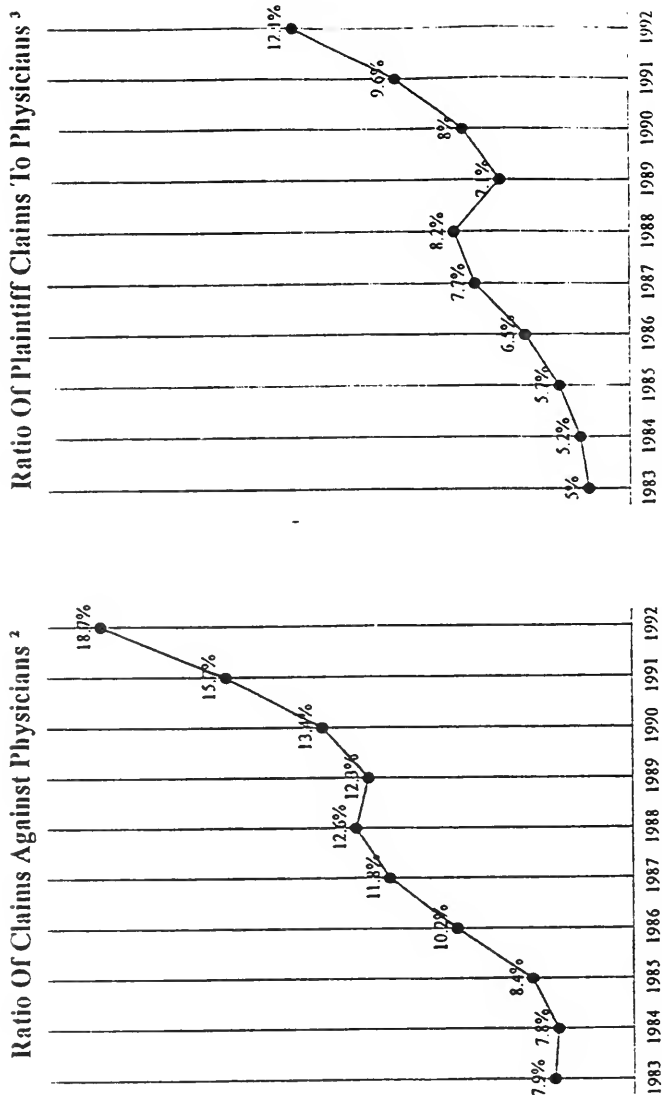
Frequency Of Claims Against Physicians

Year	Estimated Number Of Active Patient Care Physicians in Texas ¹	Number of Claims Against Physicians ²	Ratio Of Claims Against Physicians	Number of Plaintiff Claims ³	Ratio Of Plaintiff Claims Against Physicians
1983	22,133	1,745	7.9%	1,116	5.0%
1984	22,991	1,793	7.8%	1,190	5.2%
1985	23,849	2,004	8.4%	1,355	5.7%
1986	24,673	2,516	10.2%	1,605	6.5%
1987	25,528	3,013	11.8%	1,976	7.7%
1988	26,382	3,331	12.6%	2,164	8.2%
1989	26,612	3,276	12.3%	1,893	7.1%
1990	26,992	3,612	13.4%	2,146	8.0%
1991	27,894	4,376	15.7%	2,673	9.6%
1992	28,796	5,396	18.7%	3,496	12.1%

Developed By Health Care Financing Dept., Division Of Medical Economics, Texas Medical Association

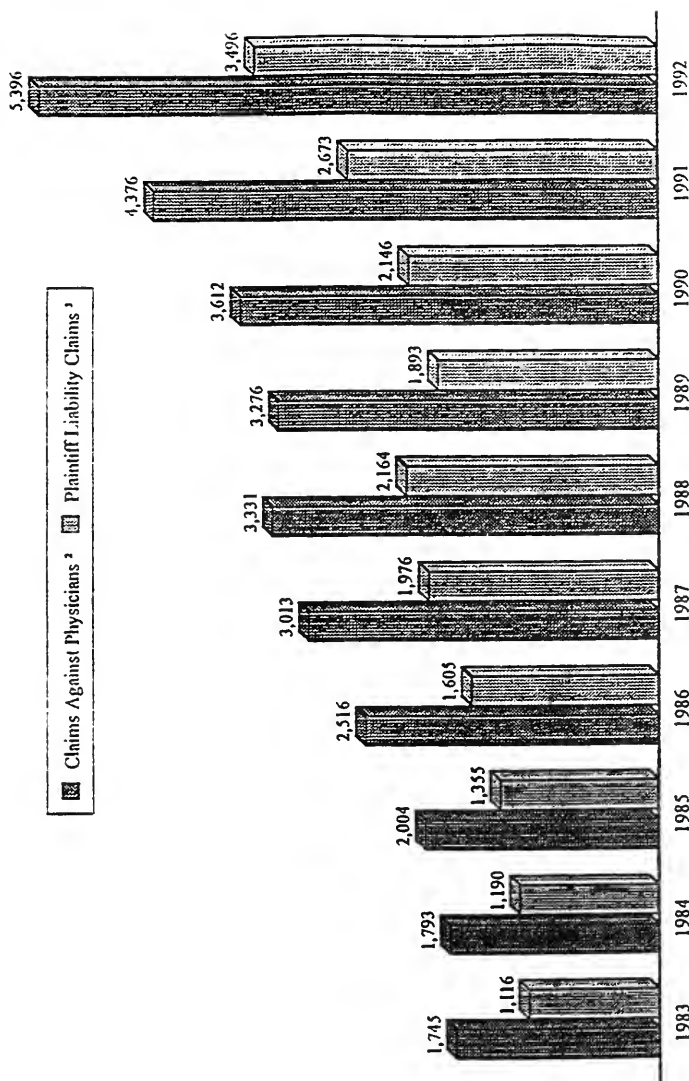
Frequency Of Claims Against Physicians

Chart 2



Developed By Health Care Financing Dept., Division Of Medical Economics, Texas Medical Association

Claims Against Physicians



Developed By Health Care Financing Dept., Division Of Medical Economics, Texas Medical Association

Chart 4A

Illustration of Claims Frequency Against Physicians For Counties (over 100,000 population)
with Highest Percentage of Physicians Receiving Claims *

1988 Data			1990 Data			1992 Data		
County name	Percentage of physicians who received claims		County name	Percentage of physicians who received claims		County name	Percentage of physicians who received claims	
INDALGO	12.0%		INDALGO	21.5%		INDALGO	29.6%	
ICTOR	18.8%		CAMERON	19.8%		MONTGOMERY	29.3%	
JUFTERSON	16.6%		MONTGOMERY	15.7%		CAMERON	19.2%	
MONTGOMERY	15.8%		JEFFERSON	15.1%		WEBB	18.6%	
BRAZOS	15.6%		FORT BEND	14.5%		WILLIAMSON	18.2%	
WEBB	15.3%		NUECES	13.1%		NUECES	17.4%	
NUECES	15.1%		TARRANT	12.4%		TARRANT	15.9%	
BRAZORIA	14.0%		MIDLAND	12.2%		LUBBOCK	15.6%	
CAMERON	13.9%		HARRIS	11.6%		JUFTERSON	15.1%	
DINTON	13.2%		BRAZORIA	10.7%		SMITH	14.8%	
EL PASO	11.8%		EL PASO	10.6%		HARRIS	14.7%	
TARRANT	10.6%		POTTER	10.0%		WICHITA	13.3%	
McLENNAN	10.5%		SMITH	10.0%		BRAZORIA	14.0%	

Chart 4B

HARRIS	10.0%	ECTOR	9.7%	BRAZOS	14.0%
WILLIAMSON	9.9%	TAYLOR	9.6%	MIDLAND	13.5%
MIDLAND	9.8%	LUBBOCK	9.4%	BELL	11.9%
TRAVIS	9.8%	DALLAS	9.4%	POTTER	11.9%
FORT DEND	9.1%	COLLIN	9.3%	EL PASO	11.8%
POTTER	9.0%	MCLENNAN	9.0%	GREGG	11.7%
LUBBOCK	9.0%	BEXAR	8.8%	TAYLOR	11.1%
SMITH	8.1%	WEBB	8.7%	FORT DEND	10.9%
DALLAS	8.0%	BRAZOS	8.4%	DALLAS	10.1%
GREGG	7.9%	TRAVIS	8.4%	TRAVIS	9.8%
BEXAR	7.8%	WILLIAMSON	8.3%	MCLENNAN	9.5%
COLLIN	6.6%	DUNTON	6.9%	DUNTON	9.3%
BELL	6.4%	GREGG	6.2%	ECTOR	8.9%
TAYLOR	5.8%	GALVESTON	5.8%	BEXAR	8.9%
WICHITA	5.1%	WICHITA	4.8%	COLLIN	8.1%
GALVESTON	4.4%	BELL	3.5%	GALVESTON	6.3%
State-wide	10.8%		11.6%		14.4%

Developed By Health Care Financing Dept., Division Of Medical Economics, Texas Medical Association

Chart 5A

Frequency Of Claims Against Physicians By County (Over 100,000 population) For 1992

Sorted By Ratio Of Defendant Claims Against Physicians

County Name	Defendant Claims 1992 ¹	Plaintiff Claims 1992 ¹	Unduplicated Physicians Receiving Claims ²	Number of Active Patient Care Texas Physicians ³	Ratio of Claims Against Physicians		Ratio of Claims Per 10,000 Population	
					Defendant Claims	Plaintiff Claims	Defendant Claims	Plaintiff Claims
HIDALGO	219	100	89	301	0.23	0.33	383,545	5.71
MONTGOMERY	61	42	31	116	0.54	0.36	182,201	3.46
WEBB	30	22	113	21	0.27	0.19	133,239	2.25
CAMERON	65	46	49	255	0.25	0.18	260,120	2.50
HARRIS	1,682	1,123	1,059	7,205	0.23	0.16	2,818,199	5.98
JEFFERSON	99	63	69	457	0.22	0.14	239,397	4.14
TARRANT	335	225	223	1,221	0.19	0.13	1,170,103	2.86
LUBBOCK	123	69	100	643	0.19	0.11	222,636	3.52
NUBES	106	81	100	576	0.18	0.14	291,145	3.64
WILLIAMSON	16	9	16	88	0.18	0.10	139,551	1.15
DRAZORIA	30	19	24	171	0.19	0.11	191,707	1.36
WICHITA	43	19	36	252	0.12	0.08	122,278	3.31
POTTER	63	44	44	370	0.17	0.12	97,814	6.44
SMITH	54	35	34	314	0.16	0.10	151,309	3.57
DELI.	79	37	521	62	0.15	0.07	191,088	4.13
EL PASO	118	86	97	825	0.14	0.10	591,610	1.99
MIDLAND	18	15	17	126	0.14	0.12	109,611	1.62
FORT BEND	36	21	29	266	0.14	0.08	225,421	1.60
ECTOR	19	13	13	146	0.13	0.09	118,934	1.60
IRAZOS	21	17	24	172	0.12	0.10	121,862	1.72
DENTON	27	20	21	225	0.12	0.09	273,571	0.99
TRAVIS	146	103	123	1,261	0.12	0.08	576,407	2.53
DALLAS	523	378	469	4,546	0.12	0.08	1,852,810	2.82
IRIXAR	332	223	268	3,018	0.11	0.07	1,185,394	2.80
McLENNAN	30	21	27	383	0.11	0.07	189,123	1.59
QALVESTON	91	58	55	888	0.10	0.07	217,399	4.19
TAYLOR	20	16	23	208	0.10	0.08	119,655	1.67
ORRICO	12	11	171	171	0.07	0.06	104,948	1.14
COLLIN	22	16	26	321	0.07	0.05	264,036	0.81
Statewide	5,396	3,496	4,161	28,796	0.19	0.12	16,986,510	3.18

Chart 5B

Frequency Of Claims Against Physicians By County (Over 100,000 population) For 1992

Sorted By Ratio of Plaintiff Claims Against Physicians

County Name	Defendant Claims 1992	Plaintiff Claims 1992	Unduplicated Physicians Receiving Claims	Number of Active Patient Care Texas Physicians	Ratio of Claims Against Physicians		Ratio of Claims Per 10,000 Population	
					Defendant Claims	Plaintiff Claims	Defendant Claims	Plaintiff Claims
MONTGOMERY	63	42	34	116	0.54	0.36	182.201	3.46
HIDALGO	219	100	89	301	0.73	0.33	383.545	5.71
WEBB	30	22	21	113	0.27	0.19	133.239	2.25
CAMERON	65	46	49	255	0.25	0.18	260.120	2.50
HARRIS	1,685	1,123	1,059	7,205	0.23	0.16	2,818.199	5.98
HUEBES	106	81	100	576	0.18	0.14	201.145	3.64
JEFFERSON	99	63	69	451	0.22	0.14	239.197	4.14
TARRANT	335	225	273	1,721	0.19	0.13	1,170.103	2.86
MIDLAND	18	15	17	126	0.14	0.12	106.611	1.69
KOTLER	63	44	44	370	0.17	0.12	278.874	6.44
BRAXORIA	30	19	24	171	0.18	0.11	191.707	1.56
LUBBOCK	123	69	100	643	0.19	0.11	222.616	5.52
EL PASO	118	86	97	825	0.14	0.10	321.610	1.92
WILLIAMSON	16	9	16	88	0.18	0.10	139.551	1.15
SMITH	34	35	51	344	0.16	0.10	151.309	3.57
BRAXOS	21	17	24	172	0.12	0.10	121.862	1.72
ECTOR	19	13	13	146	0.13	0.09	118.934	1.60
DENTON	27	20	21	225	0.12	0.09	223.525	0.99
DALLAS	523	378	469	4,546	0.12	0.08	1,952.810	2.82
TRAVIS	146	103	123	1,261	0.12	0.08	576.407	2.53
FORT BEND	36	21	29	266	0.14	0.08	225.421	1.60
TAYLOR	20	16	23	208	0.10	0.08	119.655	1.67
WICHITA	43	19	36	252	0.17	0.08	122.378	3.51
McLENNAN	30	21	27	283	0.11	0.07	189.123	1.59
BEXAR	332	223	268	3,018	0.11	0.07	1,185.394	2.80
BIEL	79	37	62	521	0.15	0.07	191.088	4.13
GALVESTON	91	58	55	888	0.10	0.07	217.299	4.19
OREGO	12	11	20	171	0.07	0.06	104.948	1.14
COLLIN	22	16	26	321	0.07	0.05	264.036	0.83
Statewide	5,396	3,496	4,161	28,796	0.19	0.12	16,986.510	3.18

CHART 5C

Frequency Of Claims Against Physicians By County (Over 100,000 population) For 1992

Sorted By Ratio Defendant Claims Per 10,000 Population

County Name	Defendant Claims 1992 ¹		Plaintiff Claims 1992 ¹	Unsubstantiated Physicians		Number of Active Patient Care Team Physicians ²		Ratio of Claims Against Physicians				Ratio of Claims Per 10,000 Population	
	Charges	Settlements		Receiving Claims ³	Not Receiving Claims ³	Physicians	Physicians	Defendant	Plaintiff	Defendant	Plaintiff	Defendant	Plaintiff
JACKSON	63	44	44	370	0.17	0.12	97,874	6.44	4.50				
HARRIS	1,685	1,123	2,205	2,205	0.23	0.16	2,018,199	5.98	3.98				
HUNTER	219	100	89	643	0.73	0.33	383,545	5.71	2.61				
HUNTER	133	69	100	643	0.19	0.11	222,636	5.52	3.10				
DAVALL	91	58	88	88	0.10	0.07	217,199	4.19	2.67				
JEFFERSON	99	63	69	457	0.73	0.14	239,397	4.14	2.63				
BELL	79	37	61	521	0.15	0.07	191,088	4.13	1.94				
MURKIN	106	81	100	376	0.19	0.14	291,145	3.64	2.78				
SMITH	54	35	51	344	0.16	0.10	151,309	3.57	2.31				
WICHITA	43	19	36	352	0.17	0.08	123,278	3.51	1.55				
MONTEGOMERY	63	42	116	116	0.34	0.26	182,201	3.46	2.31				
TARRANT	335	225	273	1,721	0.19	0.12	1,170,103	3.86	1.92				
DALLAS	523	378	469	4,546	0.12	0.08	1,852,810	3.82	2.04				
DEKAR	323	223	268	3,219	0.11	0.07	1,183,394	2.77	1.88				
TRAVIS	146	103	123	123	0.12	0.08	576,407	2.53	1.79				
CAMERON	65	46	49	235	0.23	0.18	260,120	2.50	1.77				
WEBB	30	22	13	113	0.27	0.12	133,239	2.45	1.65				
EL PASO	118	96	93	935	0.14	0.10	991,610	1.99	1.45				
BRAZOS	21	17	24	172	0.12	0.10	121,862	1.73	1.40				
MIDLAND	18	13	17	126	0.14	0.12	106,611	1.67	1.41				
TAYLOR	20	16	23	208	0.10	0.08	119,655	1.47	1.34				
ECTOR	19	13	13	146	0.13	0.09	118,934	1.60	1.09				
FORT BEND	36	21	29	265	0.14	0.08	225,421	1.89	0.93				
MALENNAN	30	21	27	283	0.11	0.07	189,173	1.59	1.11				
BRAZORIA	30	19	24	171	0.18	0.11	191,707	1.56	0.99				
WILLIAMSON	16	9	88	88	0.18	0.10	139,551	1.15	0.64				
OREGO	12	11	20	20	0.07	0.06	104,948	1.14	1.05				
DINTON	27	20	23	223	0.12	0.09	273,525	0.99	0.73				
COLLIN	22	16	26	321	0.07	0.05	264,036	0.83	0.61				
Statewide	5,396	3,496	4,161	28,796	0.19	0.12	16,996,510	3.18	2.06				

Chart 5D

Frequency Of Claims Against Physicians By County (Over 100,000 population) For 1992

Sorted By Ratio Plaintiff Claims-Per 10,000 Population

County Name	Defendant		Plaintiff		Unduplicated Physician		Number of Active Patient		Physicians		Ratio of Claims Per	
	Claims 1992 ¹	Claims 1992 ²	Claims 1992 ³	Claims 1992 ⁴	Physicians	Physicians	Case Texas Physicians ⁵	Case Texas Physicians ⁶	Defendant	Plaintiff	Defendant	Plaintiff
POTTER	63	44	44	44	370	0.17	0.12	97,874	6.41	4.50		
JARRIS	1,685	1,123	1,059	1,059	7,205	0.23	0.16	2,818,199	5.98	3.98		
LUBBOCK	123	69	63	100	643	0.19	0.11	222,636	5.52	3.10		
NUECES	106	81	576	100	576	0.18	0.14	291,145	3.64	2.78		
GUADALUPE	91	58	888	55	888	0.10	0.07	217,399	4.19	2.67		
JEFFERSON	99	63	457	69	457	0.22	0.14	219,397	4.14	2.63		
HIDALGO	219	100	301	89	301	0.23	0.13	383,545	5.71	2.61		
SMITH	54	35	344	31	344	0.16	0.10	151,309	3.57	2.31		
MONTGOMERY	63	42	116	34	116	0.54	0.36	182,201	3.46	2.31		
DALLAS	523	378	4,546	469	4,546	0.12	0.08	1,852,810	2.82	2.01		
DELL	79	37	521	62	521	0.15	0.07	191,088	4.13	1.91		
TARRANT	335	225	1,731	273	1,731	0.19	0.13	1,170,103	2.86	1.92		
BEXAR	332	273	3,018	268	3,018	0.11	0.07	1,185,394	2.80	1.88		
TRAVIS	146	103	1,261	123	1,261	0.12	0.08	576,407	2.53	1.79		
CAMERON	65	46	255	49	255	0.25	0.18	260,120	2.50	1.77		
WEED	30	22	113	21	113	0.27	0.19	133,219	2.35	1.65		
WICHITA	43	19	36	36	36	0.17	0.08	122,378	3.51	1.55		
EL PASO	118	86	835	97	835	0.14	0.10	591,610	1.99	1.45		
MIDLAND	18	15	17	17	126	0.14	0.12	106,611	1.69	1.41		
BRAZOS	21	17	24	24	172	0.12	0.10	121,862	1.72	1.40		
TAYLOR	20	16	208	23	208	0.10	0.08	119,655	1.67	1.34		
McLENNAN	30	21	283	27	283	0.11	0.07	189,123	1.59	1.11		
ECTOR	19	13	146	13	146	0.13	0.09	118,934	1.60	1.09		
OREGO	12	11	131	20	131	0.07	0.06	104,948	1.14	1.05		
BRAZORIA	30	19	171	24	171	0.18	0.11	191,707	1.56	0.99		
FORT BEND	36	21	266	29	266	0.14	0.08	235,421	1.60	0.93		
DENTON	27	20	235	23	235	0.12	0.09	233,525	0.99	0.73		
WILLIAMSON	16	9	88	16	88	0.18	0.10	139,551	1.15	0.61		
COLLIN	22	16	331	26	331	0.07	0.05	264,036	0.81	0.61		

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Statewide 5,396 3,496 4,161 28,796 0.19 0.12 16,986,510 3.18 2.06

Developed By Health Care Financing Dept., Division Of Medical Economics, Texas Medical Association

Chart 6

County Name	Defendant Claims 1992 ¹	Plaintiff Claims 1992 ¹	Unduplicated Physicians Receiving Claims ¹	Number of Active Patient Care Texas Physicians ¹	Ratio of Claims Against			Ratio of Claims Per		
					Physician Defendant Claims	Plaintiff Claims	Physician Population ¹	Defendant Claims	Plaintiff Claims	10,000 Population
SCURRY	3	2	2	9	0.22	0.27	18,534	1.07	1.07	1.07
SHELBY	3	3	1	11	0.27	0.27	22,034	1.36	1.36	1.36
SMITH	34	35	51	344	0.16	0.10	151,309	3.57	2.31	2.31
SOMERVELL	1	1	0	3	0.33	0.33	5,360	1.87	1.87	1.87
STAIR	6	4	5	8	0.35	0.50	40,318	1.48	0.99	0.99
STEPHENS	2	2	0	5	0.40	0.40	9,010	2.22	2.22	2.22
SUTTON	1	1	1	1	1.00	1.00	4,135	2.42	2.42	2.42
SWISHER	1	1	0	3	0.33	0.33	8,133	1.23	1.23	1.23
TARRANT	335	235	273	1,721	0.19	0.13	1,170,103	2.86	1.92	1.92
TAYLOR	30	16	23	208	0.10	0.08	119,655	1.67	1.31	1.31
TERRY	1	1	2	8	0.13	0.13	13,218	0.76	0.76	0.76
TITUS	3	2	5	30	0.10	0.07	24,009	1.25	0.83	0.83
TOMORRIN	7	6	10	174	0.04	0.03	98,458	0.71	0.61	0.61
TRAVIS	146	103	123	1,361	0.12	0.08	576,407	2.53	1.70	1.70
TYLER	3	2	2	9	0.33	0.22	16,646	1.80	1.20	1.20
UPSOUR	4	4	3	14	0.29	0.29	31,370	1.28	1.28	1.28
UVALDE	3	2	3	16	0.19	0.13	23,340	1.29	0.86	0.86
VAL VERDE	7	4	7	31	0.33	0.19	38,721	1.81	1.01	1.01
VICTORIA	14	10	16	150	0.09	0.07	74,361	1.88	1.34	1.34
WALKER	3	3	6	42	0.07	0.07	50,917	0.59	0.59	0.59
WARD	2	2	1	4	0.50	0.50	13,115	1.53	1.53	1.53
WASHINGTON	3	3	4	39	0.08	0.08	26,154	1.15	1.15	1.15
WEBB	30	22	21	113	0.27	0.19	133,239	2.25	1.65	1.65
WILARTON	12	9	10	49	0.34	0.18	39,955	3.00	2.25	2.25
WICHLITA	43	19	36	252	0.17	0.08	127,376	3.41	1.55	1.55
WILBARGER	3	2	4	17	0.29	0.12	15,121	3.31	1.32	1.32
WILLACY	2	1	5	5	0.40	0.20	17,205	1.13	0.56	0.56
WILLIAMSON	16	9	16	88	0.18	0.10	119,551	1.15	0.64	0.64
WISB	2	2	1	14	0.14	0.14	34,679	0.58	0.58	0.58
WOOD	2	2	4	17	0.12	0.12	29,380	0.68	0.68	0.68
YOUNG	2	2	2	12	0.17	0.17	18,126	1.10	1.10	1.10
ZAVALA	2	2	2	4	0.50	0.50	12,162	1.64	1.64	1.64
Totals	4,913	3,298	3,681	28,437	0.17	0.12	16,996,667	2.05	1.45	1.45
Statewide **	5,396	3,496	4,161	28,796	0.19	0.12	16,986,510	2.06	1.18	1.18

* Table only includes counties in which claims were filed.

** Statewide totals include claims for which the county was not specified.

Developed by Health Care Financing Dept., Division Of Medical Economics, Texas Medical Association

Chart 7

Claims Against Physicians By Specialty, 1988, 1990, and 1992

Each physician can receive more than one claim

Specialty Name	1988				1990				1992			
	Claims Received	Physician Population	Claims to number of physicians	Claims Received	Physician Population	Claims to number of physicians	Claims Received	Physician Population	Claims to number of physicians	Claims Received	Physician Population	Claims to number of physicians
Anesthesiology	117	1,590	7.4%	168	1,639	10.3%	194	1,721	11.0%			
Cardiovascular Diseases	133	680	19.6%	149	687	21.7%	211	733	28.8%			
Dermatology	9	378	2.4%	21	384	5.5%	18	419	9.1%			
Diagnostic Radiology	50	741	6.7%	68	755	9.0%	91	874	10.4%			
Emergency Medicine	97	533	18.2%	129	545	23.7%	147	598	24.6%			
Family Practice	349	2,790	12.5%	384	2,881	13.3%	343	3,103	11.1%			
Gastroenterology	11	149	8.9%	26	321	7.4%	33	371	8.9%			
General Practice	169	1,440	11.7%	142	1,368	10.4%	146	1,241	11.7%			
General Surgery	277	1,983	14.0%	324	1,988	16.3%	460	2,064	22.3%			
Internal Medicine	254	3,708	6.9%	275	3,754	7.3%	378	4,215	8.9%			
Neurological Surgery	88	237	34.2%	100	256	39.1%	93	269	34.6%			
Neurology	45	411	10.9%	59	422	14.0%	74	473	15.6%			
Obstetrics and Gynecology	396	1,933	20.6%	470	1,956	24.0%	563	2,101	26.8%			
Oncology	11	133	8.3%	22	132	15.8%	40	142	28.2%			
Ophthalmology	60	871	6.9%	77	877	8.8%	155	902	17.2%			
Orthopedic Surgery	336	1,033	32.5%	323	1,061	30.4%	401	1,139	35.3%			
Otolaryngology	63	468	13.5%	59	484	12.2%	84	503	16.7%			
Pulmonary	42	710	5.9%	44	735	5.6%	76	866	8.8%			
Pediatrics	136	1,919	8.1%	120	1,981	6.1%	163	2,192	7.4%			
Plastic Surgery	97	280	34.6%	101	291	34.7%	617	304	301.0%			
Psychiatry	68	1,350	5.0%	64	1,402	4.6%	117	1,513	7.7%			
Pulmonary Diseases	24	259	9.3%	17	267	6.4%	44	286	15.4%			
Radiology	111	438	25.3%	126	464	27.2%	171	401	42.6%			
Thoracic Surgery	50	131	38.2%	46	131	35.1%	61	134	49.3%			
Urology	99	511	19.4%	94	512	18.4%	143	501	28.5%			
Other	199	1,009	19.7%	204	1,610	12.7%	318	1,658	19.2%			
Statewide	3,331	26,282	12.6%	3,612	26,992	13.4%	5,396	28,796	18.7%			

Developed By Health Care Financing Dept., Division Of Medical Economics, Texas Medical Association

Chart 8

Chains Against Physicians By Specialty, 1988, 1990, and 1992
Unfulfilled number of physicians receiving chains

Specialty Name	1988				1990				1992			
	Physicians With Chains	Physician Population	% of Physicians Receiving Chains	Physicians With Chains	Physician Population	% of Physicians Receiving Chains	Physicians With Chains	Physician Population	% of Physicians Receiving Chains	Physicians With Chains	Physician Population	% of Physicians Receiving Chains
Anesthesiology	110	1,590	6.9%	130	1,639	9.2%	180	1,711	10.5%	180	1,711	10.5%
Cardiovascular Diseases	114	680	16.8%	120	687	17.5%	175	713	24.5%	175	713	24.5%
Dermatology	9	278	2.4%	20	384	5.2%	36	419	8.6%	36	419	8.6%
Diagnostic Radiology	45	741	6.1%	59	755	7.8%	78	874	8.9%	78	874	8.9%
Emergency Medicine	82	533	15.4%	113	545	20.7%	13	598	2.2%	13	598	2.2%
Family Practice	305	2,790	10.9%	346	2,881	12.0%	468	3,103	15.1%	468	3,103	15.1%
Gastroenterology	29	349	8.3%	25	353	7.1%	43	371	11.6%	43	371	11.6%
General Practice	133	1,440	10.6%	132	1,368	9.6%	130	1,344	10.5%	130	1,344	10.5%
General Surgery	235	1,983	11.9%	274	1,988	13.8%	358	2,064	17.3%	358	2,064	17.3%
Internal Medicine	232	3,708	6.3%	252	3,754	6.7%	338	4,245	8.0%	338	4,245	8.0%
Neurological Surgery	60	257	23.3%	73	256	28.5%	78	269	29.0%	78	269	29.0%
Neurology	40	411	9.7%	52	422	12.3%	66	473	14.0%	66	473	14.0%
Obstetrics and Gynecology	332	1,923	17.3%	392	1,956	20.0%	462	2,101	22.0%	462	2,101	22.0%
Oncology	9	133	6.8%	17	139	12.2%	33	142	23.2%	33	142	23.2%
Ophthalmology	52	871	6.0%	65	877	7.4%	62	902	7.4%	62	902	7.4%
Orthopedic Surgery	238	1,013	23.0%	260	1,061	24.5%	290	1,139	25.5%	290	1,139	25.5%
Otolaryngology	56	468	12.0%	53	484	11.0%	72	503	14.3%	72	503	14.3%
Pediatrics	41	770	5.3%	38	785	4.8%	70	866	8.1%	70	866	8.1%
Pediatrics	146	1,919	7.6%	113	1,981	5.7%	151	2,192	6.9%	151	2,192	6.9%
Plastic Surgery	72	280	25.7%	80	321	27.5%	202	304	66.4%	202	304	66.4%
Psychiatry	62	1,350	4.6%	46	1,402	3.3%	96	1,513	6.3%	96	1,513	6.3%
Pulmonary Diseases	22	259	8.5%	15	267	5.6%	35	286	12.2%	35	286	12.2%
Radiology	95	438	21.7%	112	464	24.1%	154	501	30.7%	154	501	30.7%
Thoracic Surgery	41	131	31.3%	39	131	29.8%	46	124	37.1%	46	124	37.1%
Urology	89	311	28.6%	83	312	26.7%	131	301	43.5%	131	301	43.5%
Other	169	1,009	16.7%	194	1,610	12.0%	266	1,558	17.1%	266	1,558	17.1%
Statewide	2,838	26,382	10.8%	3,123	26,992	11.6%	4,161	28,796	14.4%	4,161	28,796	14.4%

Developed By Health Care Financing Dept., Division Of Medical Economics, Texas Medical Association

chart 9A

Analysis of Claims Against Physician Defendants²

Unadjusted Dollars

Claims included are filed to date of final disposition, fully closed, and indemnity payments are greater than zero.

Year	Total Closed Claims Filed	Average Amount Paid	Amount Paid Excluding Claims Closed No Indem.					Total Dollars
			25TH. Percentile	Median	75TH. Percentile	95TH. Percentile		
1983	251	\$59,675	\$4,000	\$15,000	\$45,000	\$100,000	\$14,978,627	
1984	351	\$65,549	\$7,979	\$25,000	\$85,000	\$245,000	\$23,007,905	
1985	478	\$81,250	\$6,500	\$25,000	\$100,000	\$404,662	\$18,817,750	
1986	715	\$92,162	\$6,000	\$20,000	\$100,000	\$401,100	\$65,895,996	
1987	796	\$98,939	\$7,500	\$30,000	\$100,000	\$450,000	\$78,755,711	
1988	830	\$121,649	\$11,000	\$45,000	\$150,000	\$500,000	\$100,968,963	
1989	929	\$119,211	\$10,000	\$40,000	\$102,164	\$500,000	\$110,747,500	
1990	1,214	\$139,619	\$15,000	\$50,000	\$175,000	\$525,000	\$169,498,568	
1991	1,007	\$153,848	\$20,000	\$70,000	\$175,000	\$600,000	\$154,498,568	
1992	1,191	\$169,305	\$25,000	\$93,000	\$200,000	\$588,000	\$201,880,660	

Developed By Health Care Financing Dept., Division Of Medical Economics, Texas Medical Association

Chart 9B

Analysis of Claims Against Physician Defendants ²

Adjusted To Constant Dollars Using The General Consumer Price Index

Claims included are filed to date of final disposition, fully closed, and indemnity payments are greater than zero.

Year	Total Closed Claims Filed	Average Amount Paid	Amount Paid Excluding Claims Closed No Indemn.					Total Dollars
			25TH. Percentile	Median	75TH. Percentile	95TH. Percentile		
1983	251	\$59,675	\$4,000	\$15,000	\$45,000	\$100,000	\$14,978,627	
1984	351	\$32,836	\$7,649	\$23,965	\$81,482	\$214,860	\$22,055,701	
1985	478	\$75,209	\$6,017	\$23,141	\$92,565	\$374,576	\$35,950,185	
1986	715	\$83,753	\$5,453	\$18,175	\$90,876	\$163,504	\$59,883,586	
1987	796	\$86,746	\$6,576	\$26,303	\$87,676	\$394,542	\$69,049,901	
1988	830	\$102,420	\$9,261	\$37,887	\$126,289	\$420,964	\$85,008,527	
1989	929	\$95,753	\$8,032	\$32,129	\$82,061	\$401,613	\$88,955,250	
1990	1,214	\$106,397	\$11,431	\$38,103	\$133,359	\$400,077	\$129,166,468	
1991	1,007	\$112,506	\$14,626	\$51,189	\$127,974	\$438,767	\$112,981,332	
1992	1,191	\$120,333	\$17,748	\$66,021	\$141,981	\$417,426	\$143,316,563	

Developed By Health Care Financing Dept., Division Of Medical Economics, Texas Medical Association

Chart 9c

Analysis of Claims Against Physician Defendants²Adjusted To Constant Dollars Using The Medical Consumer Price Index

Claims included are filed to date of final disposition, fully closed, and indemnity payments are greater than zero.

Year	Total Closed Claims Filed	Average Amount Paid	Amount Paid Excluding Claims Closed No Indem.					Total Dollars
			25TH. Percentile	Median	75TH. Percentile	95TH. Percentile		
1983	231	\$59,675	\$4,000	\$15,000	\$45,000	\$100,000	\$14,978,627	
1984	331	\$61,744	\$7,516	\$23,549	\$80,066	\$230,777	\$21,672,240	
1985	478	\$72,015	\$5,761	\$22,159	\$88,634	\$358,670	\$34,423,592	
1986	715	\$75,996	\$4,948	\$16,492	\$82,459	\$329,836	\$54,337,190	
1987	796	\$76,505	\$5,799	\$23,198	\$77,325	\$347,963	\$60,897,961	
1988	830	\$88,296	\$7,984	\$32,662	\$108,874	\$362,915	\$71,286,275	
1989	929	\$80,326	\$6,738	\$26,952	\$68,839	\$336,906	\$74,622,897	
1990	1,214	\$86,276	\$9,269	\$30,897	\$108,139	\$324,416	\$104,739,287	
1991	1,007	\$87,441	\$11,367	\$39,785	\$99,463	\$341,017	\$82,811,051	
1992	1,191	\$89,701	\$13,230	\$49,215	\$105,839	\$311,167	\$106,834,268	

Developed By Health Care Financing Dept., Division Of Medical Economics, Texas Medical Association

Chart 10A

Analysis of Plaintiff Liability Claims³Unadjusted Dollars

Claims included are filed to date of final disposition, fully closed, and indemnity payments are greater than zero.

Year	Total Closed Claims Filed	Average Amount Paid	Amount Paid Excluding Claims Closed No Indem.					Total Dollars
			25TH. Percentile	Median	75TH. Percentile	95TH. Percentile		
1983	200	\$72,195	\$5,000	\$20,000	\$67,500	\$313,600	\$14,438,974	
1984	282	\$80,784	\$8,750	\$25,000	\$95,000	\$395,000	\$22,781,065	
1985	381	\$97,652	\$6,375	\$27,500	\$100,000	\$468,807	\$37,205,213	
1986	549	\$110,350	\$7,500	\$25,000	\$100,000	\$521,357	\$60,581,996	
1987	643	\$112,003	\$9,350	\$35,000	\$100,000	\$500,000	\$72,017,913	
1988	663	\$139,466	\$12,500	\$50,000	\$180,000	\$600,000	\$92,466,205	
1989	703	\$135,843	\$10,000	\$40,000	\$145,000	\$550,721	\$95,497,475	
1990	872	\$181,726	\$15,000	\$63,750	\$200,000	\$751,454	\$158,465,402	
1991	753	\$186,973	\$20,000	\$70,000	\$200,000	\$750,000	\$140,790,253	
1992	857	\$204,316	\$25,000	\$93,000	\$250,000	\$800,000	\$175,098,844	

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Chart 103

Analysis of Plaintiff Liability Claims²

Adjusted To Constant Dollars Using The General Consumer Price Index

Claims included are filed to date of final disposition, fully closed, and indemnity payments are greater than zero.

Year	Total Closed Claims Filed	Average Amount Paid	Amount Paid Excluding Claims Closed No Indem.					Total Dollars
			25TH, Percentile	Median	75TH, Percentile	95TH, Percentile		
1983	200	\$72,195	\$5,000	\$20,000	\$67,500	\$313,600	\$14,438,974	
1984	282	\$77,441	\$8,388	\$23,965	\$91,068	\$378,653	\$21,838,249	
1985	381	\$90,392	\$5,901	\$25,455	\$92,565	\$433,951	\$34,439,045	
1986	549	\$100,282	\$6,816	\$22,719	\$90,876	\$473,788	\$55,054,442	
1987	643	\$98,200	\$8,198	\$30,687	\$87,676	\$438,380	\$63,142,466	
1988	663	\$117,420	\$10,524	\$42,096	\$151,547	\$505,156	\$77,849,823	
1989	703	\$109,113	\$8,032	\$32,129	\$116,468	\$442,353	\$76,706,016	
1990	872	\$138,484	\$11,431	\$48,381	\$152,410	\$572,646	\$120,758,638	
1991	753	\$136,729	\$14,626	\$51,189	\$146,256	\$548,458	\$102,957,115	
1992	857	\$145,045	\$17,748	\$66,021	\$177,477	\$567,926	\$124,303,955	

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Chart 10C

Analysis of Plaintiff Liability Claims³

Adjusted To Constant Dollars Using The Medical Consumer Price Index

Claims included are tied to date of final disposition, fully closed, and indemnity payments are greater than zero.

Year	Total Closed Claims Filed	Average Amount Paid	Amount Paid Excluding Claims Closed No Indem.				Total Dollars
			25TH. Percentile	Median	75TH. Percentile	95TH. Percentile	
1983	200	\$72,195	\$5,000	\$20,000	\$67,500	\$313,600	\$14,418,974
1984	282	\$76,094	\$8,242	\$23,549	\$89,485	\$372,069	\$21,458,569
1985	381	\$86,553	\$5,650	\$24,374	\$88,634	\$415,524	\$32,976,621
1986	549	\$90,994	\$6,184	\$20,615	\$82,459	\$429,906	\$49,955,318
1987	643	\$86,606	\$7,230	\$27,064	\$77,325	\$386,626	\$55,687,918
1988	663	\$101,229	\$9,073	\$36,291	\$130,649	\$435,498	\$67,114,720
1989	703	\$91,533	\$6,738	\$26,952	\$97,703	\$371,082	\$64,347,260
1990	872	\$112,395	\$9,269	\$39,393	\$123,587	\$464,351	\$97,921,495
1991	753	\$106,268	\$11,367	\$39,785	\$113,672	\$426,271	\$80,020,055
1992	857	\$108,123	\$13,230	\$49,215	\$132,299	\$423,356	\$92,661,461

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Chart 11

Physician Claim Analysis: Claims Filed More Than Two Years After The Date Of Incident

	Number of physician defendant claims *	Percent of Total	Number of physician defendant claims with two year difference *	Claims with two year difference as a percent of total claims
Basis Of Claim				
No response	709	2.3%	113	16%
Not yet determined	2,090	6.7%	214	10%
Failure to Diagnose	4,119	13.3%	985	24%
Failure to Operate	40	0.1%	10	25%
Failure to Treat	1,373	4.4%	269	20%
Negligent Diagnosis	1,493	4.8%	360	24%
Negligent Surgery	6,543	21.1%	1,446	22%
Negligent Treatment	13,972	45.0%	2,780	20%
Failure of Consent	358	1.2%	77	22%
Breach of Confidence	15	0.0%	0	0%
Unnecessary Surgery	350	1.1%	76	22%
Totals	31,062	100%	6,330	20%
Location of Incident				
No response	887	2.9%	152	17%
0 (unknown variable)	3,985	12.8%	628	16%
Hospital	21,269	68.5%	4,592	22%
Emergency room	1,116	3.6%	13	11%
Nursing home	127	0.4%	13	10%
Outpatient	1,015	3.3%	212	21%
Office	2,610	8.4%	605	23%
Patients home	53	0.2%	5	9%
Totals	31,062	100%	6,330	20%
Specialty				
Obstetrics and Gynecology	3,904	12.6%	822	21%
Plastic Surgery	1,534	4.3%	484	36%
Family Practice	3,270	10.5%	559	17%
Orthopedic Surgery	2,771	8.9%	544	20%
General Surgery	2,817	9.1%	473	17%
Internal Medicine	2,215	7.1%	434	20%
Pediatrics	1,187	3.8%	338	28%
General Practice	1,500	4.8%	289	19%
Radiology	1,044	3.4%	247	24%
Neurological Surgery	751	2.4%	197	26%
Diagnostic Radiology	460	1.5%	118	26%
Anesthesiology	1,305	4.2%	136	10%
Ophthalmology	672	2.2%	139	21%
Psychiatry	582	1.9%	123	21%
Cardiovascular Diseases	706	2.3%	120	17%
Cardiovascular Surgery	518	1.7%	91	18%
Otolaryngology	586	1.9%	102	17%
Urological Surgery	608	2.0%	27	4%
Emergency Medicine	851	2.7%	78	9%
Other	3,981	12.8%	1,009	25%
Totals	31,062	100%	6,330	20%

* Two year filing period includes a 75 day grace period.

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Claim Filing - Number Of Days From Incident, 1983-92

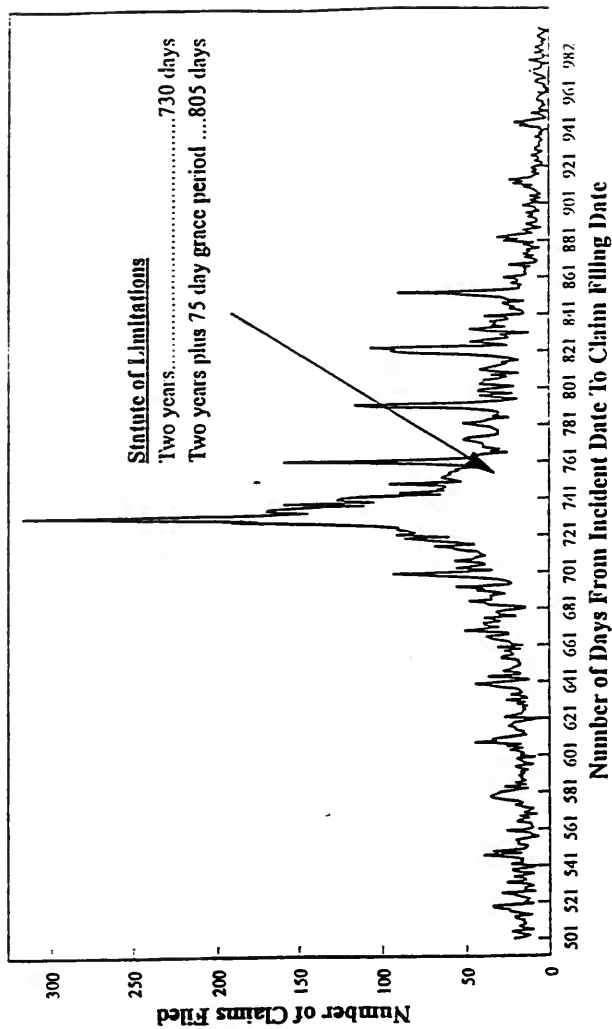


Chart 13

Physician Defendant Claim Outcome

Payment data tied to the date of the claim, independent of the date of disposition.

Year	Claims Closed Indemnity Paid				Claims Closed No Indemnity Paid			
	Total Claims Filed	Claims Open	Claims Closed	Percent Of Claims Closed	Number Of Claims	Percent Of Total Claims	Number Of Claims	Percent Of Total Claims
1983	1,745	114	1,631	93%	631	37.3%	980	60.1%
1984	1,793	103	1,690	94%	709	39.5%	981	58.0%
1985	2,004	137	1,867	93%	770	38.4%	1,097	58.8%
1986	2,316	312	2,004	88%	805	32.0%	1,399	63.5%
1987	3,013	413	2,600	86%	967	32.1%	1,633	62.8%
1988	3,331	548	2,783	84%	928	27.9%	1,855	66.7%
1989	3,276	587	2,689	82%	781	23.8%	1,908	71.0%
1990	3,612	992	2,620	73%	699	19.4%	1,921	73.3%
1991	4,376	2,037	2,339	53%	574	13.1%	1,765	75.5%
1992	5,396	3,764	1,632	30%	258	4.8%	1,374	84.2%
Totals	31,062	9,807	22,055	71%	7,142	23.8%	14,913	67.6%

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NOTES

- ¹ Active Patient Care Physicians is based on the American Medical Association's Physician Characteristics and Distribution in the U.S. These figures do not include physicians in administrative, teaching, or research positions.
- ² "Claims Against Physicians" is a count of every claim reported to the Texas State Board of Medical Examiners. It indicates the extent to which physicians are affected by claims.
- ³ A plaintiff's claim represents a single episode which may result in claims filed against more than one physician. It can provide a quantifiable measure of litigiousness.
- ⁴ To quantify the number of physicians directly affected by claims, a determination was made of the number of physicians in each county or specialty who had received at least one claim during a specific time period. This number is referred to as "Unduplicated Physicians Receiving Claims" and is smaller than the total number of claims against physicians because some physicians received more than one claim. When sorted by county, the unduplicated physicians are sorted by practice address, whereas claims are classified by the county in which the incident occurred. Some physicians currently practice out of state.
- ⁵ Population is from 1990 U. S. Census.

Appendix

Claims Against Physicians By Specialty

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	Total
Obstetrics and Gynecology	102	134	162	216	232	253	333	481	396	403	470	557	563	4,302
Family Practice	92	129	142	165	168	202	264	308	349	379	384	508	543	3,633
General Surgery	125	110	128	171	184	226	257	260	277	307	324	351	460	3,480
Orthopedic Surgery	74	106	130	171	186	220	245	246	316	266	232	377	401	2,990
Internal Medicine	30	55	68	89	107	112	177	218	254	257	275	348	378	2,368
Other	46	50	51	86	97	90	122	136	164	156	284	258	320	1,860
General Practice	92	102	103	120	132	161	167	175	169	145	142	143	146	1,797
Plastic Surgery	36	37	34	58	52	54	68	76	97	86	101	125	617	1,441
Anesthesiology	37	39	55	116	75	68	110	143	117	145	168	169	194	1,436
Pediatrics	24	33	38	62	65	80	110	136	156	129	120	166	163	1,282
Radiology	25	22	30	61	55	60	69	100	111	117	126	174	171	1,121
Emergency Medicine	25	26	27	36	21	35	65	70	97	113	129	138	147	929
Neurological Surgery	21	37	33	47	44	50	71	79	88	60	100	119	91	812
Cardiovascular Diseases	16	21	27	36	45	50	50	62	69	61	93	104	136	770
Ophthalmology	22	28	20	32	41	45	47	56	60	53	77	106	155	742
Psychiatry	11	17	22	29	27	20	20	48	68	59	64	115	132	632
Urological Surgery	27	19	27	39	36	35	61	47	78	79	70	74	89	681
Otolaryngology	14	25	35	33	32	42	45	73	63	75	59	80	84	660
Cardiovascular Surgery	8	18	17	32	28	33	36	52	64	67	56	75	75	561
Diagnostic Radiology	4	8	13	19	18	30	24	41	50	53	68	63	91	485
Thoracic Surgery	15	15	15	39	27	42	35	38	50	41	46	46	61	470
Neurology	6	8	13	17	31	19	42	34	45	50	59	53	74	451
Pathology	9	7	12	22	23	17	5	29	42	42	44	71	76	399
Gynecology	26	25	23	17	18	14	25	31	42	43	24	40	29	357
Gastroenterology	8	10	9	12	16	16	24	31	31	30	26	35	53	301
Pulmonary Diseases	1	2	5	5	5	9	15	9	24	25	17	24	44	185
Dermatology	8	6	5	3	15	12	15	13	9	21	21	24	38	190
Oncology	4	2	3	5	6	6	6	8	11	10	22	23	40	146
Infectious Diseases	0	2	2	7	7	3	8	10	14	4	11	10	23	101
Grand Totals	908	1,093	1,249	1,745	1,793	2,004	2,516	3,013	3,331	3,276	3,612	4,376	5,396	34,112

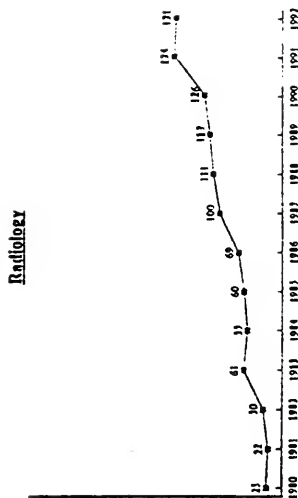
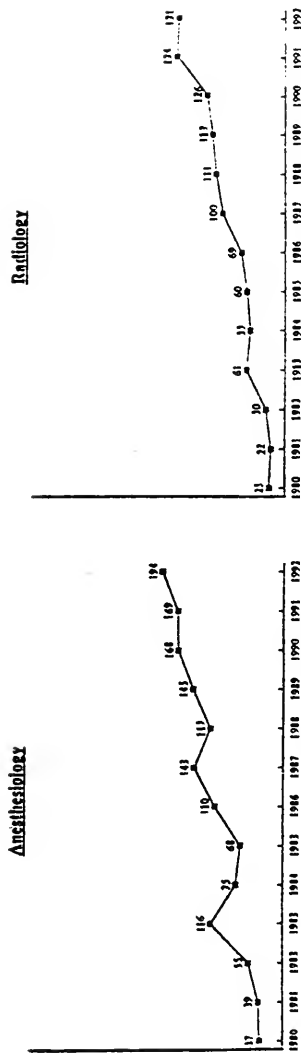
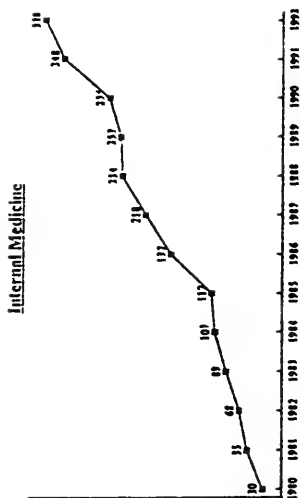
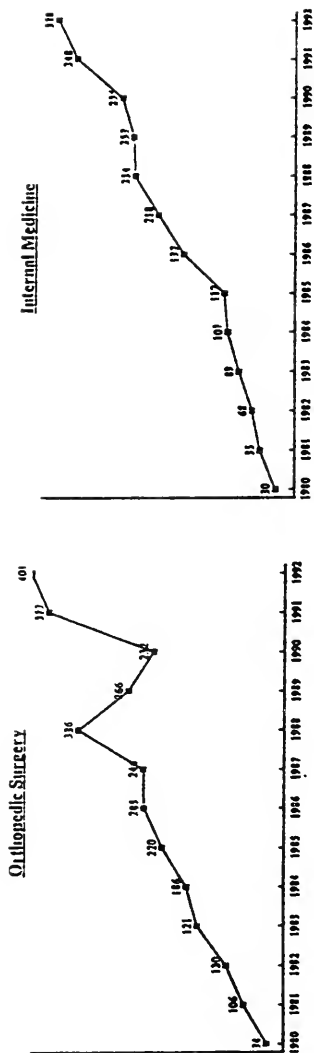
* Total excludes incomplete 1993 data.

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Claims Against Physicians By Specialty

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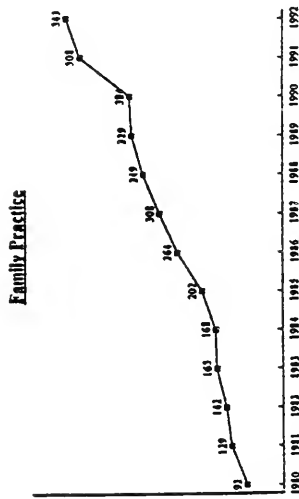
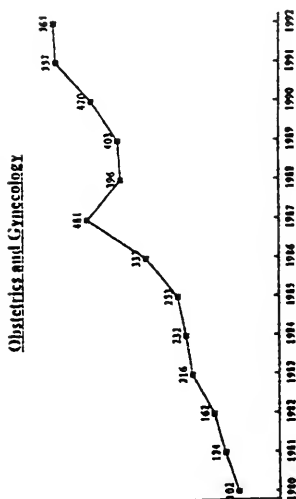
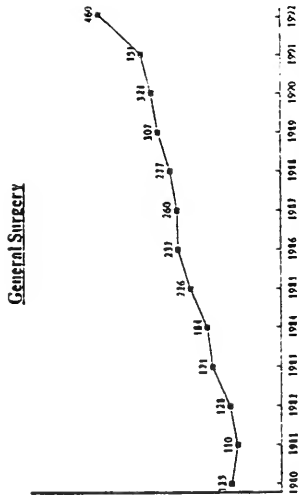
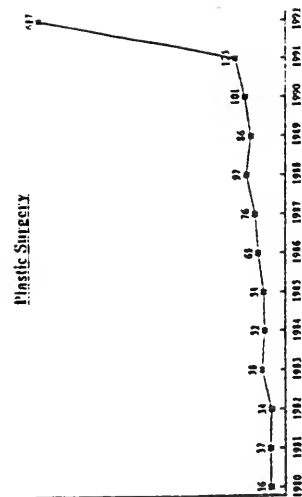
Appendix



Claims Against Physicians By Specialty

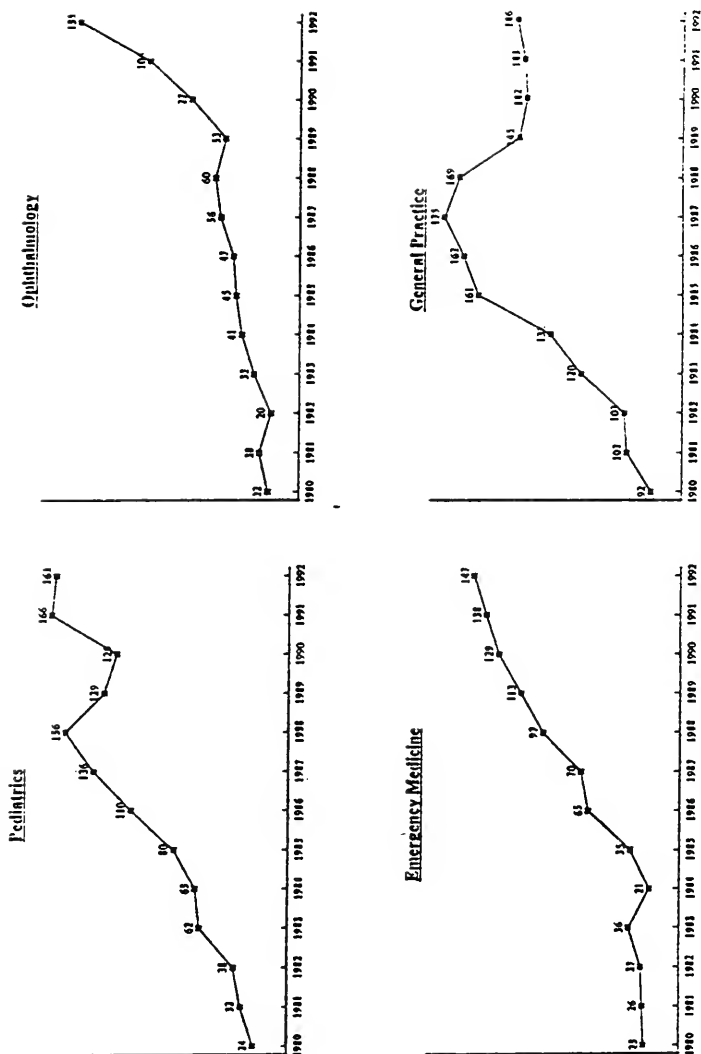
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Appendix

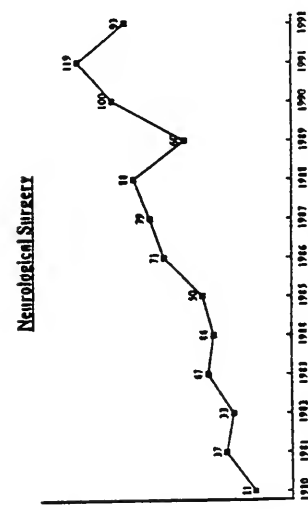
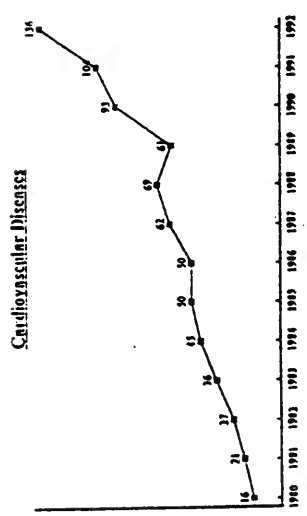
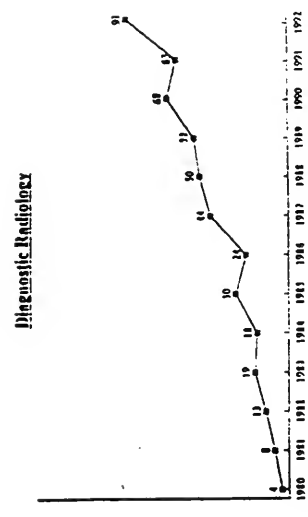
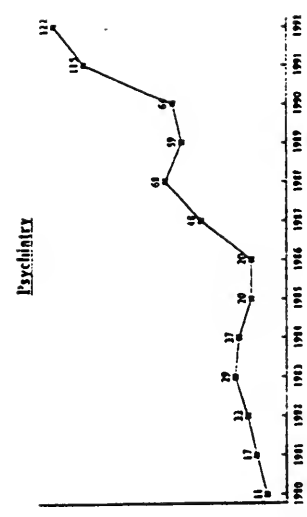


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Claims Against Physicians By Specialty

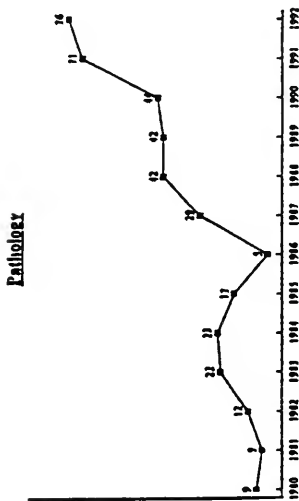
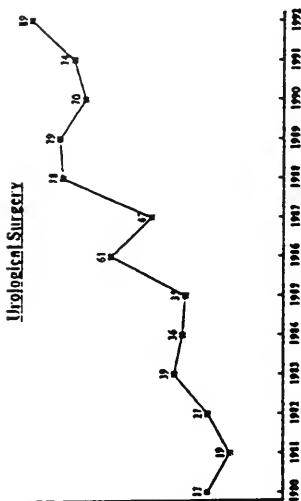
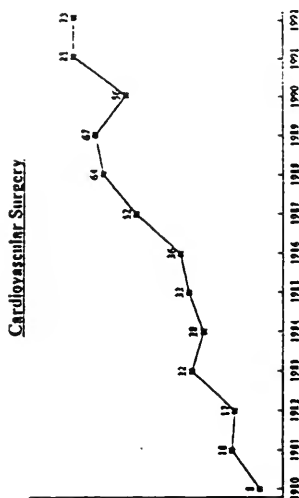
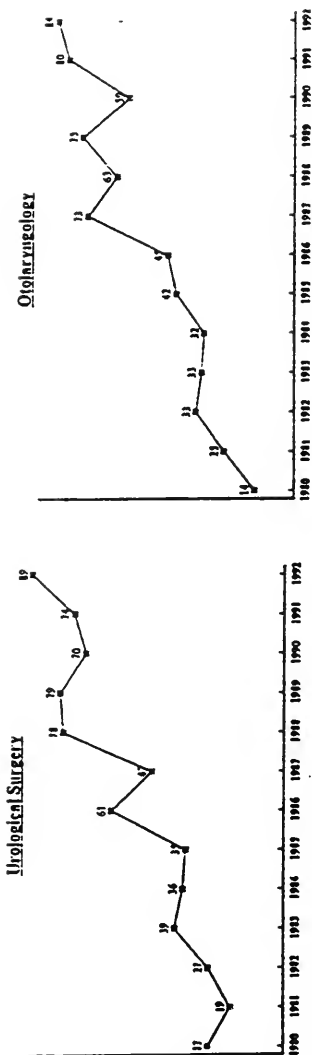


Claims Against Physicians By Specialty

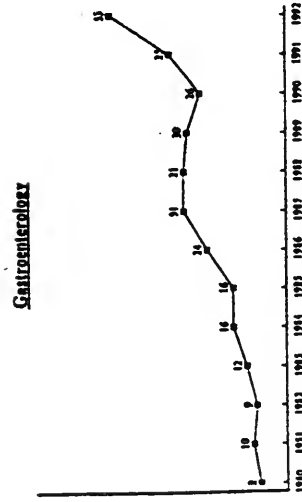
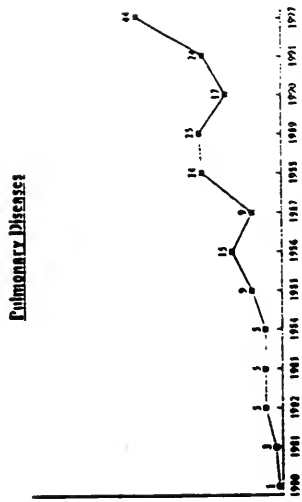
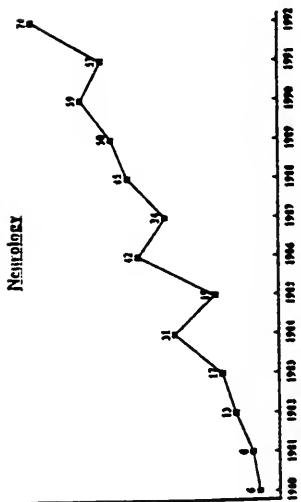
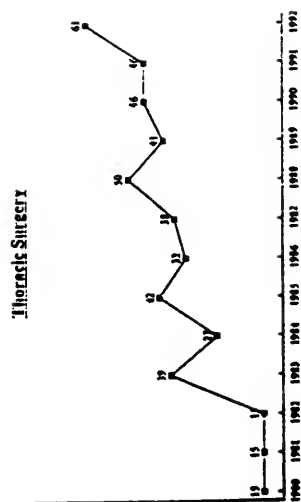


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Claims Against Physicians By Specialty

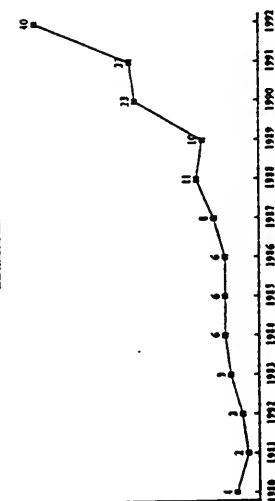


Claims Against Physicians By Specialty

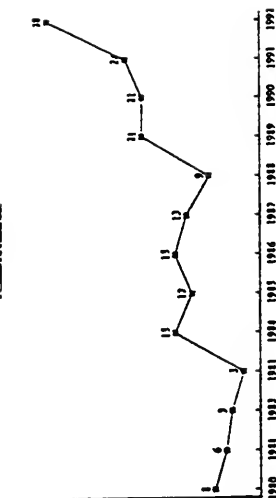


Claims Against Physicians By Specialty

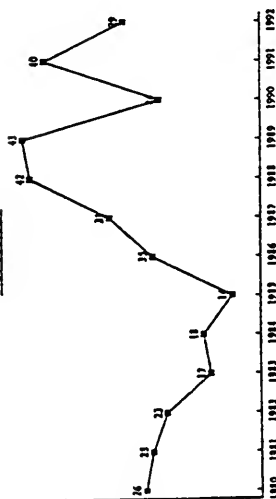
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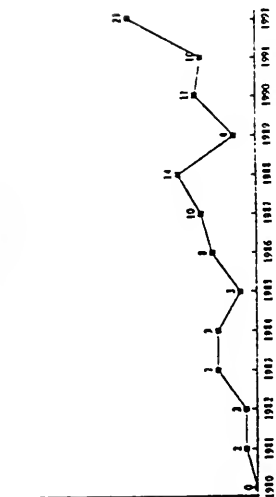
Dermatology



Gynecology



Infectious Diseases



Appendix E

NO. 86-CT-10557

GILBERTO and ROSARIO ALVAREZ,
Individually and as Next Friend
of AURORA ALVAREZ, a Minor

VS.

ROBERTO M. GONZALEZ, M.D., DR.
ROBERTO M. GONZALEZ CORP. P.A.,
GONZALEZ MEDICAL SURGICAL
CENTER and RAMIREZ-GONZALEZ
MEDICO-SURGICAL FAMILY CLINIC

IN THE DISTRICT COURT

45TH JUDICIAL DISTRICT

BEXAR COUNTY, TEXAS

AGREED FINAL JUDGMENT

On this day came on to be heard the above-styled and numbered cause, wherein GILBERTO AND ROSARIO ALVAREZ, INDIVIDUALLY AND AS NEXT FRIENDS FOR AURORA ALVAREZ, A MINOR, are Plaintiffs; and ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER AND RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC are Defendants.

It appearing to the Court that AURORA ALVAREZ is a minor, suing by and through her next friends, GILBERTO and ROSARIO ALVAREZ, both of whom also have individual claims, and the Court being of the opinion that there might be a conflict of interest between said Minor and her next friends, the Court has heretofore appointed Gene Toscano as Guardian Ad Litem for said Minor Plaintiff.

All Parties appeared by and through their respective attorneys of record and appearance was also made by the Guardian Ad Litem and all present announced to the Court that they had agreed to compromise and settle all matters in dispute and at issue between them, subject to the approval of the Court. It was further announced that the Guardian Ad Litem had made his investigation and had determined that the agreement of the Parties was fair and just and in the best interests of his ward, AURORA ALVAREZ, and that in the opinion of the Guardian Ad Litem said agreement should be ratified and approved by the Court. The Parties' written Compromise Settlement Agreement has been filed with the Court and examined by the Court. The Court further examined the pleadings and heard the evidence presented by the Parties regarding the occurrence made the subject of Plaintiffs' suit, the resulting injuries and damages alleged, the manner in which those injuries were alleged to have been received, and the nature.

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extent and effect of same. After considering all of the facts and circumstances and studying the Compromise Settlement Agreement executed by the Parties, their respective attorneys of record and the Guardian Ad Litem, and with the recommendation of the Guardian Ad Litem, the Court is of the opinion and finds that the Compromise Settlement Agreement is, under all of the facts and circumstances, fair and reasonable, that it is in the best interest of the minor child, AURORA ALVAREZ, and that such Agreement should be ratified and approved by the Court.

The Court further finds, after hearing all of the evidence, that the settlement consideration, both the present payments and future payments as herein set forth, are to be paid as full and final settlement of all claims of Plaintiff, GILBERTO and ROSARIO ALVAREZ, individually, and as Next Friend for AURORA ALVAREZ, a minor.

IT IS THEREFORE ORDERED, ADJUDGED AND DECREED by the Court that the Compromise Settlement Agreement filed with the Court is ratified and approved in all respects. IT IS FURTHER ORDERED by the Court that Plaintiffs GILBERTO and ROSARIO ALVAREZ, individually and as next friends for AURORA ALVAREZ, a minor, do have and recover of and from ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P A . GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ GONZALEZ MEDICO-SURGICAL FAMILY CLINIC, the sum of TWO HUNDRED THOUSAND DOLLARS (\$200,000.00), out of which sum all attorney's fees and expenses of Plaintiffs herein, including those of the minor Plaintiff, are to be paid.

IT IS FURTHER ORDERED by the Court that Defendants shall make future payments to the minor Plaintiff AURORA ALVAREZ, by and through her legal guardian, in the amount of EIGHT HUNDRED FORTY AND 08/100THS DOLLARS (\$840.08) per month. Said monthly payments shall commence on Apr. 26, 1987 with all future monthly payments continuing thereafter payable on the first day of each and every month throughout the lifetime of the minor Plaintiff, AURORA ALVAREZ, or for twenty (20) years (240 monthly payments), whichever is longer. Beginning on April 26, 1988, the monthly payments will be increased at the rate of 3% per annum, compounded annually and increased every year thereafter on the anniversary date of April 26 during the total time that such payments shall be made. In the event the minor Plaintiff, AURORA ALVAREZ, dies prior to March 26, 2007, then all future monthly

payments, through and including March 26, 2007, shall be made jointly to her parents, GILBERTO ALVAREZ and ROSARIO ALVAREZ. Unless otherwise provided, all future payments made in accordance with the terms of this Judgment shall be paid to the legal guardian of the minor Plaintiff, AURORA ALVAREZ, for the use and benefit of AURORA ALVAREZ.

IT IS FURTHER ORDERED that TEXAS MEDICAL LIABILITY TRUST, the insurer of Defendants ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC, as a matter of right, and in its sole discretion, may elect to assign the duties and obligations to make the future payments herein ordered to be made by Defendants ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC; and that such assignment, if made, shall be accepted and binding upon Plaintiffs GILBERTO and ROSARIO ALVAREZ, Individually, and as Next Friends of AURORA ALVAREZ, a minor, without right of rejection, in full discharge and release of the duties and obligations of ROBERTO M. GONZALEZ, M.D., DR. ROBERTO GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC and the TEXAS MEDICAL LIABILITY TRUST to make such future payments.

IT IS FURTHER ORDERED that if TEXAS MEDICAL LIABILITY TRUST elects to assign Defendants' and its duties and obligations to make the aforesaid future payments to METROPOLITAN PROPERTY AND LIABILITY COMPANY, Plaintiffs and the Guardian Ad Litem be, and they are hereby authorized, empowered and ordered to execute a "Release and Satisfaction of Judgment" as to ROBERTO M. GONZALEZ, M.D., DR. ROBERTO GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER, RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC and TEXAS MEDICAL LIABILITY TRUST. METROPOLITAN PROPERTY AND LIABILITY COMPANY shall thereafter be solely responsible for the duties and obligations to make such future payments.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that when ROBERTO M. GONZALEZ, M.D., DR. ROBERTO GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICAL SURGICAL FAMILY CLINIC or their insurer have paid the aforesaid sums presently due unto the Plaintiffs and TEXAS MEDICAL LIABILITY TRUST has made the assignment of Defendants' and its duties and obligations to make the future payments as provided for herein,

that this Judgment shall be deemed fully satisfied, and Defendants ROBERTO M. GONZALEZ, M.D., DR. ROBERTO GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC and the TEXAS MEDICAL LIABILITY TRUST, and any agent, servant, employee or principal thereof, shall stand fully, finally and forever acquitted and discharged of and from any and all claims, demands or causes of action asserted in this cause, or which could, may or might have been asserted by GILBERTO and ROSARIO ALVAREZ, Individually, and as Next Friend for AURORA ALVAREZ, a Minor, by reason of the medical treatment, care and injuries complained of in Plaintiffs' Original Petition on file herein; and Plaintiffs and the Guardian Ad Litem are ordered to then promptly execute and deliver to said Defendants the aforesaid Release and Satisfaction of Judgment.

It appearing to the Court that the recovery of the Plaintiffs should be apportioned between the minor Plaintiff, AURORA ALVAREZ, Plaintiffs, GILBERTO ALVAREZ and ROSARIO ALVAREZ, and their attorneys, Tinsman & Houser, Inc., and after having heard the recommendations of the Guardian Ad Litem for the minor Plaintiff;

IT IS ORDERED, ADJUDGED AND DECREED that the recovery to the Plaintiffs in the sum of TWO HUNDRED THOUSAND DOLLARS (\$200,000.00) in cash, and the future payments be apportioned as follows:

- (1) The Plaintiff, GILBERTO ALVAREZ, have and recover from the Defendants the sum of \$ 10,000.00 in cash;
- (2) The Plaintiff, ROSARIO ALVAREZ, have and recover from the Defendants the sum of \$ 10,000.00 in cash;
- (3) The minor Plaintiff, AURORA ALVAREZ, have and recover from the Defendants the sum of \$ 19,153.93 in cash; said sum to be paid to the legal guardian of the minor Plaintiff, AURORA ALVAREZ;
- (4) The minor Plaintiff, AURORA ALVAREZ, have and recover from the Defendants future monthly payments as provided for herein; those being \$840.08 per month, increasing at 3% per annum, the first payment to be Apr. 26, 1987 and continuing for the life of AURORA ALVAREZ or twenty (20) years, whichever is longer;
- (5) The attorneys for the Plaintiffs, Tinsman & Houser, Inc.,

have and recover the sum of \$ 260,843.07 in cash as attorneys' fees for representing the Plaintiffs, GILBERTO ALVAREZ and ROSARIO ALVAREZ, and the minor Plaintiff AURORA ALVAREZ, in this action, said sum to include reimbursement of all expenses incurred and to be incurred on the Plaintiffs' behalf in this suit.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED by the Court that all costs of Court herein shall be paid by the Defendants, ROBERTO M. GONZALEZ, M.D., DR. ROBERTO M. GONZALEZ CORP. P.A., GONZALEZ MEDICAL SURGICAL CENTER and RAMIREZ-GONZALEZ MEDICO-SURGICAL FAMILY CLINIC, including a fee of \$ 5000⁰⁰, which shall be paid to the Guardian Ad Litem, Gene Toscano, for his services as such, and which said fee is hereby taxed as part of the Court costs in this suit and should be paid by said Defendants.

SIGNED this 18TH day of March, 1987.

Robert Scott
JUDGE PRESIDING

APPROVED:

Gene Toscano

State Bar I.D. No. 20145000

GUARDIAN AD LITEM FOR AURORA ALVAREZ,
A MINOR

TINSMAN & HOUSER, INC.
1900 National Bank of Commerce Bldg.
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By:

Robert Scott
Robert Scott
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ATTORNEYS FOR PLAINTIFFS

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By:

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Donald G. Hale
State Bar I.D. No. 09834200

ATTORNEYS FOR DEFENDANTS AND
TEXAS MEDICAL LIABILITY TRUST

The Best Paid Lawyers in America

You've heard about those crazy damages suits, those huge awards, the insurance rates crunch. Well, it's an ill liability crisis that blows no one any good—\$10 billion a year's worth.

The plaintiff attorneys' great honey rush

"We are freedom fighters. We all consider ourselves social engineers. We are crusaders of good. None of us do it for the money; what we are paid is coincidental."

—That's Ned Good speaking, Pasadena plaintiff attorney, member of the Inner Circle and on *FORBES'* list of the highest-earning attorneys in the nation. Good was reluctant to discuss how much money he coincidentally makes in the course of his crusade, but *FORBES* estimates it's almost certainly more than \$3.5 million a year.

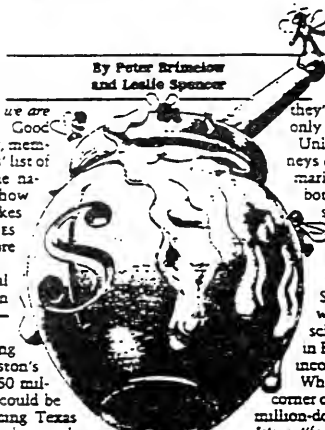
Roil over, Wall Street. Meet the real champions of the great American greed game: the plaintiff attorneys—lawyers who specialize in suing.

Top moneymaker in 1988, according to *FORBES'* count (p. 204), was Houston's Joe Jamail. He made most of his \$450 million—our conservative estimate; it could be as high as \$600 million—by inducing Texas courts to accept the questionable theory that Pennzoil had a binding contract to buy Getty Oil even though there was nothing on paper. His victim, Texaco, the country's third-largest oil company, was forced into bankruptcy. But Jamail received only a fraction of the publicity Mike Milken got for the \$550 million he made with Drexel Burnham back in 1987.

Jamail is merely the most spectacular example to date of a powerful emerging trend. The 62 other plaintiff attorneys on *FORBES'* list all made above \$2 million in both 1987 and 1988. And *FORBES* has identified at least 15 more \$2-million-a-year-plus suspects, with another 50 in the \$1-million-to-\$2-million range. Then there are the other 53,000 plaintiff attorney members of the Washington, D.C.-based Association of Trial Lawyers of America (despite its name a plaintiff attorneys' lobby; Defense lawyers are eligible only for nonvoting membership). Given the windfall nature of the attack-lawyer business, any of them might strike it rich with a single case.

One measure of the money flowing to plaintiff attorneys: Yeshiva University's Cardozo School of Law Professor Lester Brickman estimates that their total income from contingent fees—their share of the settlement, apart from their expenses—"exceeds \$10 billion."

By Peter Brimelow
and Leslie Spencer



And their boodie is growing rapidly. The top moneymakers on *FORBES'* list typically said that they've been hitting the big numbers only for the last decade.

Unlike Wall Streeters, plaintiff attorneys don't have to worry about the stock market's swings. They mostly didn't bother with high-priced Ivy League law schools—in fact, they often say they "didn't learn a thing about practicing law in law school." Walter Umphrey (see *law*) even told *FORBES* that he had trouble graduating from Southern Methodist University, which he attended on a football scholarship, because of "a deficiency in English." But he has no deficiency in income: \$14.5 million in 1988.

Why has a single, relatively obscure corner of U.S. legal practice created so many million-dollar incomes?

It's a "fearful concatenation of circumstances," to quote a famous early American trial lawyer, Daniel Webster. In one of those institutional accidents that occasionally happen in a structured but dynamic society, the checks and balances that normally restrain an organized interest group have failed, creating an opportunity to hold the rest of the economy to ransom. Other recent examples: stockbrokers in the 1960s, who were able to make institutional investors pay full commission rates because stock exchange rules forbade volume discounts; airline pilots in the 1970s, whose powerful unions extorted stratospheric salaries out of an industry straitjacketed by regulation.

How has this happened?

The essential mechanism is simple. Two distinctively American phenomena have interacted: the contingent fee system and the "liability crisis," the explosion of litigation and awards that has occurred during the last 30 years in the previously sleepy area of tort law—the law of accidents and personal injury. Both have been historically unknown in other common-law jurisdictions, such as Britain. And plaintiff attorneys there are a lot poorer.

A startlingly large part of the recent massive damage awards goes to the lawyers. Plaintiff attorneys commonly

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insist on a contingency fee of 33% to 40%. Plus they get expenses—whatever has been spent to litigate the case. The actual outcome varies among the different classes of tort. But, for example, the Rand Corp.'s Institute for Civil Justice has estimated that in the asbestos claims settled in the early 1980s, plaintiff attorneys' fees and expenses amounted to some 70 cents for every dollar that the injured parties received.

And by one estimate the asbestos industry's liability may be anywhere from \$7.6 billion to \$87 billion.

Why has this happened?

The lid was knocked off the honey pot in the last 30 years by judges arbitrarily deciding to rewrite the law (Forbes, June 1, 1987). The plaintiff attorneys are swarming to the sweet stuff like flies. But for the plaintiff attorneys, their new wealth has meant power. Those swarming flies are now rocking the pot to spill more honey out—and buzzing angrily at anyone who interferes.

Plaintiff attorneys buzz particularly angrily at talk of the litigation explosion.

"We have been told that Americans are the most litigious people in the world," writes the celebrated Wyoming-based plaintiff attorney Gerry Spence in his 1989 book *With Justice for None: Destroying an American Myth* (Times Books). "Yet, per capita, there are no more suits today than there were in 1959, and the amount of the mean verdict, \$5,000, has remained nearly constant since that year after adjustments for inflation have been calculated."

This is the sort of argument that makes the innocent observer suspect mal lawyers. On investigation, the Rand study that Spence cites turns out to be based on the single experience of Cook County, Ill., between 1960 and 1979 only. Although the overall number of civil jury trials was only slightly higher at the beginning and the end of the period, within that number there was rapid growth of nonautomobile torts. And Spence has confused the mean (arithmetical average) financial award with the median (half higher, half lower) award. The mean rose sharply—because the largest awards were increasing dramatically.

Subsequent studies show these trends have continued. The bulk of tort filings and awards, routine personal injuries such as automobile cases, are growing at a stable rate. But malpractice and product liability filings and awards are sharply higher than three decades ago (see charts). Inflation-adjusted average awards in Rand's sample of business/contract tort litigation were up 9,100% between 1960 and 1984. (Awards can be reduced on appeal, but they have a pervasive effect because they serve as a benchmark for all settlements.) Overall, plaintiffs are winning more frequently and getting more.

And this may not be the whole story. "The real amounts being transferred in the channels of commerce are much greater than any statistics will show," says James Sales of Houston's Fulbright & Jaworski, who was local lead counsel on Texaco's unsuccessful appeal against Pennzoil.

Sales says that many cases are now settled before being formally filed—and that recent settlements have actually exceeded comparable jury awards because defendants "are scared to bet the company anymore."

Forbes' conclusion about the litigation explosion: All that plaintiff attorney honey is coming from somewhere.

Forbes' conclusion about Gerry Spence: difficult, because he refused to talk to us on the grounds that we work for "the new oligarchy—namely corporate America." "The last guerrilla fighters in the country are the trial lawyers." But he's probably stuffing some \$1.5 million a year into his bandolier.

A man is injured after he deliberately throws himself in front of a New York subway train. He sues the city, alleging the driver should have stopped faster, and wins \$650,000.

Another example: Spanish-speaking farmhands in Texas accidentally kill a prize bull with pesticide because they couldn't read the warning label. Their employer sues the manufacturer and is awarded \$8.5 million, including \$7 million of punitive damages. Later, the case settles out of court.

But these judicial atrocities are just the culmination of a step-by-step process that began in theoretical arguments among legal intellectuals in law schools and on the bench some 30 years ago—a classic demonstration that ideas do have consequences. Forbes columnist Peter W. Huber, author of *Liability: The Legal Revolution and its Consequences* (Basic Books) and himself a lawyer and engineer, calls the men who started the process—including William Prosser of Hastings College, John Wade of Vanderbilt University Law School, Roger Traynor of the California Supreme Court—"the Founders." Judges under their influence overthrew the common law of tort as it had developed over six centuries. The chaos that has replaced it has been highly profitable to the plaintiff bar.

For example, before the 1960s, damages could generally be collected only under a number of fixed conditions—if the defendant was actually at fault, if the plaintiff had not contributed to the accident, if the plaintiff had not voluntarily assumed obvious risk and so on. Private contracts, which covered most transactions, were considered inviolate. But gradually, judges undermined these conditions. Defendants, particularly if they are perceived to have "deep pockets," have begun to find they run the risk of losing lawsuits even if their involvement is minimal. Even the most specific contracts to the contrary are ignored.

"In a nutshell, the law now says 'Be careless, get paid,'" summarizes Victor E. Schwartz, a partner with Washington, D.C.'s Crowell & Moring and a tort reform lobbyist.

Similarly, judges have allowed a proliferation of ever-more-ingenious damage claims. Formerly, damages were primarily a question of compensating the plaintiff for out-of-pocket costs, like medical expenses. Now nonmeasurable damage claims like "pain and suffering," "loss of consortium" (a spouse's company) and "mental anguish"



The lid was knocked off the honey pot in the last 30 years by judges arbitrarily deciding to rewrite the law. The plaintiff attorneys are swarming to the sweet stuff like flies. But for the plaintiff attorneys, their new wealth has meant power. Those swarming flies are now rocking the pot to spill more honey out—and buzzing angrily at anyone who interferes.

have burgeoned. And "punitive" damages in product liability cases, upheld only three times in the first 100 years of U.S. history, have become an epidemic. Even compliance with federal regulatory standards does not protect defendants against them.

"Since the 1960s, courts have become more political," says Schwartz. "Also, there is a feeling on the part of judges that the U.S. is behind in not having a comprehensive social welfare system. Tort law has become a system of social insurance."

Judges opened the honey pot because they wanted to redistribute the wealth. Plaintiff attorneys want to help.

Partly, plaintiff attorneys help to keep the honey flowing by sheer relentless pressure. They are intensely motivated to come up with new moneymaking gambits.

Would you believe "hedonic damages"—the value an accident victim would have placed on his future happiness

in addition to his loss of earnings, pain and suffering, his spouse's loss of consortium, etc., etc.? How about "posthumous pain and suffering"? New York's Robert Sullivan (Forbes' income estimate: \$1.4 million) once won \$1.5 million in extra damages for the four seconds in which a truck accident victim burned to death ("We got doctors to testify his brain exploded"). Or the Big Apple Pothole Corp.—a private pothole census founded by Manhattan plaintiff attorney Fred Queller. Forbes' income estimate: \$1.25 million, to counter New York's attempt to restrict its liability only to accidents involving potholes or which it had been informed.

Quantity counts as well as quality. A plaintiff attorney firm often has few principals and many support staff because much of its litigation can be mass-produced boiler-plate, sometimes designed simply to overwhelm the defense. These can be class actions, another feature of the "legal revolution," but plaintiff lawyers prefer filing individual suits en masse. Class action fees can be limited by the judge. This mass production, presumably, is how Melvin Belli (\$2.5 million) came to file a claim in the Dupont Plaza Hotel fire case on behalf of an injured woman's husband, who had been dead for years.

And the files' campaign to rock the honey pot is helped by its accumulating financial momentum. For example, monies won by plaintiff attorneys against the Dalkon Shield contraceptive case went directly to finance further lawsuits against other (and safer) contraceptives and morning-sickness drugs.

A more complex factor: the disintegration of the traditional code of legal ethics. In his book on the litigation explosion due next year from E.P. Dutton, Manhattan Institute Senior Fellow Walter Olson argues that the "legal revolution" has also seen the effective erosion of long-standing rules against barratry (inciting clients to litigate). "The old rules told lawyers to sit around passively and wait for business," says Olson. "The new rules encourage them to recruit clients, stoke their grievances and run the suit for maximum dollar output."

The traditional code was enforced partly by statute and judicial rulings, but also by consensus within the profession. Now, however, many plaintiff attorneys are openly hostile to its restraints. This year John O'Quinn, number 5, \$8 million, justified his hiring nonlawyers to solicit clients on the grounds that this "case running" should be legalized in Texas. An attempt to disbar him failed.

But the plaintiff attorneys' most important leverage on the honey pot is provided by their interlocking relationship with two key groups: judges and politicians.

The yellow-feeling between lawyers and judges is one of the more obvious facts of life. So obvious that some years ago a judge admitted frankly in an opinion that invalidating contingent fees was "an unpleasant task for courts, especially this one, for it has practiced law for so long in the vineyard before coming to the bench and recognizes the difficulties of maintaining a law office. . . ."

Symbolically, New York's Jacob Fuchsberg, ex-president of ATLA and founder of its magazine *Trial*, spent some years as a judge on New York's Court of Appeals before returning to his vineyard (no Forbes vineyard estimate, but he says it's a "multimillion-dollar" one).

In some states, and at the federal level, judges are appointed. But the American Bar Association rating system, which has become a crucial test for judicial nominees, is weighted toward trial experience—even for appellate courts, although they focus exclusively on points of law. This obviously favors both the plaintiff and defense bars over corporate lawyers and legal academics.

Where judges are elected, the role of the plaintiff attorneys has become notorious: campaign contributions. In Texas, the fundraising drive supported by Joe Jamail and Pat Maloney (\$6 million) was so successful that, according to one Texas attorney, "until last year the plaintiff bar owned and controlled the Texas Supreme Court." And Maloney is confident that 1988's election reversal will be corrected in 1990: "We are resilient, and we will bounce back."

It is another obvious fact of life that many politicians are lawyers. Sixty out of 100 U.S. senators and 186 out of 435 House members have law degrees. At least 48 senators and 161 House members have been practicing lawyers, including majorities on both Senate and House Judiciary Committees. Perhaps the most significant: Senator Ernest Hollings (D-S.C.), a trial attorney and a founder of ATLA's predecessor, now chairman of the Senate Commerce Committee, where he is ideally placed to stop tort reform legislation.

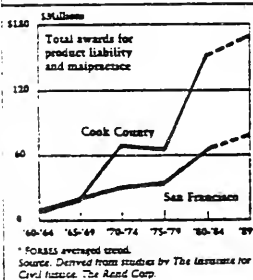
ATLA has given money to 1,485 Congressional Democrats and 656 Republicans since 1977. In 1987-88, it disbursed \$3.9 million. And this doesn't include plaintiff attorneys' individual contributions.

"They're a highly focused lobby," says tort reform lobbyist Victor Schwartz ruefully. "They've never lost on an issue before Congress."

Plaintiff attorneys are also intimately involved with state politics. "I am on a first-name basis with all the

Growth industry

Few things have risen as relentlessly as tort case awards. The dotted lines are projections, based on prior trends, in these two active markets.



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consumer organization could ask the plaintiff attorneys.

Such as: Is there enough competition between them—research suggests their contingency fees tend to “clump” at one-third and 40% of the award—just the sort of suspicious “parallel behavior” that has caused plaintiff attorneys to sue other uncouths, alleging antitrust violations. Do plaintiff attorneys disclose enough to prospective clients—should they offer a choice of contingent fees or hourly billing? Indeed, why are plaintiff attorneys allowed to demand contingent fees at all in cases where there is plainly no contingency—such as airtrash cases, in which liability is not in doubt as a practical matter, with the result that some plaintiff attorneys have received fees

equivalent to \$10,000 an hour? Or with successful plaintiff attorneys regularly choosing their cases so carefully that 95% settle out of court? Or in commercial cases, when the client is not indigent? Do clients have enough control over the expenses that plaintiff attorneys deduct from a settlement? What about practices like requiring all personal injury clients to reconfirm their hurts with particular doctors, at a high price that can be passed to the defendant? (Doctor allies are often defended by the plaintiff attorney in any malpractice suits.) What about allegations that plaintiff attorneys representing union clients sometimes pay kickbacks to the union business manager?

Public Citizen's Claybrook says she “doesn't know the answer” to fee-clumping and disclosure. “I am not a trial lawyer, and I've never gone into the issue.” Public Citizen has said that contingency fees should not exceed one-third, and where the award is large “we would hope the lawyer would take less.” Otherwise Claybrook defends contingency fees on the standard grounds that some clients can't afford hourly rates and “a plaintiff lawyer gets paid only when he wins.”

Claybrook will have an opportunity to “go into” these issues the next time Trial Lawyers for Public Justice and ATLA's Civil Justice Foundation have board meetings. She's on both.

I saw you earlier today, like sneak thieves in the night, slipping in here without nametags to snoop on our proceedings. A message to you, you medicine men of the oil slick, you fork-tongued serpents of the dollar. You have no need to sneak in here, 'cuz right after this meeting, we are coming after you. I'm tired of playing defense. . . . All the plaintiff lawyers of America are coming after you, you insurance demagogues, because we owe you one!”

Southern oratory is not dead. New Orleans' Russell Herman (FORBES income estimate: \$1.3 million) took time during his presidential address to July's ATLA Annual Convention to direct these fraternal words at another lobby, the National Conference of Insurance Legislators, convened by unhappy coincidence in the same Boston hotel.

About 3,000 plaintiff attorneys came bunning from all over the country to the weeklong convention. They attended a vast selection of lectures on technical subjects. They honored friendly journalists and judges—Chief Justice Paul Liacos of Massachusetts, and Justice Pascal Calogero of Louisiana, who thanked ATLA President Herman for “helping me continue to win elections.” They attended 35 separate “litigation groups” with names like “Silas Gel Breast Implants” and “Bic Lighters,” where they swapped information and strategies. Herman announced that a larger clearinghouse, the ATLA Exchange, is to accumulate “a cavalcade of horrors” for use by ATLA members in personal injury and other cases.

Notwithstanding a luncheon address by cool conservative columnist George Will, the convention's atmosphere was rather like a liberal version of a fundamentalist revival meeting: emotional, evangelical, moralistic. Bob Gibbins described his accepting ATLA's vice presidency as “taking on the cause for the injured and suffering, victimized, minorities and women.”

Plaintiff attorneys are an anomaly, like journalists and academics: a professional group whose politics on average are decisively to the left of others of comparable income. “There are a few Republican trial lawyers, but few in number,” says Pat Maloney. “You can pick them out, because they wear peculiar clothes.”

“Most of us are liberal Democrats,” says Mike Gallagher (\$2.5 million), recommended to FORBES as a token Republican. (But he says he supported Edward Kennedy and Lloyd Bentsen—and contributes to Ralph Nader.) Does he know any other Republican plaintiff lawyers? Gallagher chuckles: “I saw one other one, one time.”

Among some plaintiff attorneys, political alienation runs very deep indeed. “I think it's a bitter shame

about this society, the Russians have got a more responsive political system than we do,” says Herb Hafiz, would-be cleanser of America's defense industry.

This hostility toward American institutions sometimes even includes FORBES. “Why would FORBES magazine want to be here?” asked ATLA Secretary Roxanne Conlin (estimated income: \$750,000). “I mean, we sue your readership regularly, and we enjoy doing it very much.”

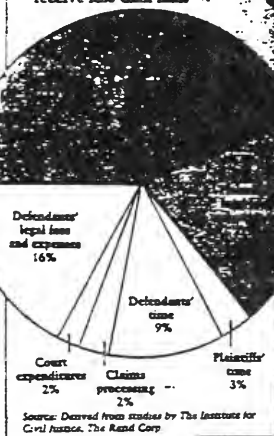
Plaintiff attorneys unquestionably believe their own rhetoric. At least ATLA's Civil Justice Foundation thinks so. Its fundraising leaflet at the convention began: “As a trial lawyer, you profit from your work in many ways—the sweet success of righting an egregious wrong, the triumph of empowering the powerless, the certain knowledge of your role in penalizing wrongdoers.”

All this and \$10 billion, too.

A specter is haunting the plaintiff attorneys—the specter of tort reform. After 30 years, the flies rocking the

Tort's troubling costs

The chart represents the total cost of tort to the economy. Of this total, the actual plaintiff attorneys receive less than half.



Brothers in back

You might as well put together a list of prostitutes and how much money they make," snarled tort lawyer and Inner Circle founder Richard Grand, when *FORBES* asked to interview him. "How would you like it if I wrote an article telling the world where you jog in Central Park?"

Grand's surliness was in sharp contrast to the clear skies over Sun Valley, Idaho, this year's venue for the annual summer meeting of the Inner Circle of Advocates—the highly exclusive fraternity of personal injury lawyers founded in 1972 to celebrate the tort industry's cherished trophy: the million-dollar verdict.

Thanks to inflation (both the monetary and legal kind), a million-dollar verdict isn't what it used to be. But the Inner Circle is more than keeping pace. To qualify today, a lawyer needs four verdicts of over a million dollars upheld on appeal. Punitive damages don't count. And membership is limited to 100 attorneys—of "high moral character."

FORBES' listing of the nation's highest-paid lawyers includes 26 Inner Circle members. Some openly boasted of their big verdicts and settlements, while others like Richard Grand wished we would go away. As Sheldon Schlesinger (who earned \$4.5 million last year) put it: "FORBES showing up here makes all these guys very nervous."

Inner Circle sessions at the annual meeting are closed-door; not even wives of this so-far all-male group are allowed to attend. But between golf and mountain biking, the "brothers," as some like to call themselves, convene to swap strategies and stories about their latest victories.

In one session, Florida's Frederic Levin, who last May won a \$5 million wrongful death case in a one day trial,

noted that his celebrity status as a local TV host is a big asset. "Every juror in Pensacola knows me," he said. Veteran Inner Circier and Californian Dave Harney recounted his winning a total lifetime payout of around \$54 million for a brain damaged child. In addition to compensating the child for a lifetime of medical care as well as for pain and suffering, says Harney, "they [the jury] have her going to college and earning \$30,000 a year by age 22. We had a neonatologist give her a normal life expectancy"—all with 5.5% to 6% interest annually.

Now you know why your doctor has to raise his fees to pay the high cost of malpractice insurance.

One contribution to the Inner Circle is Joseph Jamail's kiss (Keep it Simple Stupid! Principle. Jamies, according to Jamail, don't understand much and don't like being bombarded with facts).

A roundtable discussion focused on the plan to introduce satellite TV into the courtroom, beaming in clients and expert testimony from other cities, and even countries.

TV testimony would cost as high as \$12,000 an hour. But Inner Circle members can easily spend \$200,000 on one multimillion-dollar case.

One big benefit of Inner Circle membership: the group's expert witness database, not meant to be shared with nonmembers. These doctors, engineers and economists can demand up to \$2,000 for one day's consultation, and as much as \$10,000 for two days in trial.

Guy Allison, on *FORBES*' list at \$4 million but not a member of the Inner Circle, is unimpressed. Says he: "All the Inner Circle does is sit around and boast about their big deals. It's like boys in the locker room talking about how many girls they've... They've got a lot to brag about.—Leslie Spencer



honey pot may finally have provoked America to replace the lid.

In 1985-86 insurance rates, forced ever upward and in good part because of raids by the plaintiff lawyers, threatened to close popular public services for want of insurance. The media is publicizing useful products allegedly kept off the market for fear of litigation, notably an asbestos substitute developed by Monsanto. Peter Huber's book *Liability* has focused attention on the total "tort tax" on the economy. Huber estimates that individuals, businesses and governments pay at least \$80 billion a year directly, in such ways as litigation costs and higher insurance premiums, and a total of \$300 billion indirectly, counting the cost of efforts to avoid liability.

Ultimately, this "tort tax" is paid by the consumer. For example, an estimated 55% of the average football helmet's \$110 cost is now due to liability insurance costs. Helmetmakers on the margin have been squeezed out of business: In 1970 there were about 18, now there are 2. And sports on the margin are being squeezed out, too: A recent survey found that several hundred colleges and universities have eliminated sports such as flag football, noncompetitive diving, canoeing and hiking because of liability costs.

Partly as a result, sophisticated new tort reform lobbies are emerging—such as North Palm Beach, Fla.'s Coalition of Americans to Protect Sports and the defense bar's Washington, D.C.-based Lawyers for Civil Justice.

But the plaintiffs' attorneys are fighting back fiercely. They blame the insurance industry, sometimes striking a public chord, as when California passed Proposition 103, rolling back auto rates. Their argument is made superficially appealing as the rates crunch eases, although this is probably a cyclical phenomenon.

The battle for tort reform is now raging across the states. But it's entirely possible that it could be lost, much as no-fault automobile insurance was effectively blocked during the 1970s.

Still, some states have begun to allow courts to assess costs against frivolous actions. Perhaps this is the first step to some sort of "English rule" whereby either side must be prepared to pay the other's costs if their action is unsuccessful. Decisively altering the plaintiff's incentives to litigation, the "English rule" may be the ultimate tort reform.

Without it, the swarming plaintiff attorneys may do to the American economy what labor unions did to the British. ■

The Best Paid Trial Lawyers

The top ten

On the basis of our estimates of their 1987 and 1988 earnings, these are the country's ten highest paid trial lawyers. Other well paid trial lawyers follow.

1. JOSEPH DAHR JAMAIL

Jamail & Kolius, Houston, Tex.
1988 income: \$450 million 1987 income: \$25 million

Jamail, 63, graduated from the University of Texas law school and is best known for the victory in the 1987 Texaco-Pennzoil case that brought him an estimated \$420 million in fees. Jamail spent around \$5 million on a 19-passenger Gulfstream jet. His personal injury practice won over \$100 million in judgments and settlements in 1988, and \$75 million in 1987, of which the firm reaped about a third. "I never

wash windows," he says, "nor do I work by the hour." Recent cases include winning a \$52 million verdict in a Texas wrongful death suit that settled in 1988 for \$22 million. Jamail's seven associates are on salary and are guaranteed a percentage of profits; they also get a percentage of the cases they win. (As with all salaries in this survey, the income figures are for Jamail alone, not for his firm.)

2. HERBERT HAFF

Law Offices of Herbert Haff, Claremont, Calif.
1988 income: \$40 million 1987 income: \$15 million

Haff, 59 and a graduate of the University of Southern California law school, has brought three "whistleblower" cases against defense contractor Northrop Corp. on behalf of former and present Northrop employees and the government. His firm's tactics in these cases have already brought a \$5,000 sanction and an order to pay \$58,000 to cover Northrop's legal bills. (The order has been reduced to \$5,000.) He made national headlines with the \$540 million

he won against ComputerLand in a 1988 tort case he brought on behalf of MicroVest. That judgment gave Haff 5% of the company's stock, worth \$25 million; he now represents ComputerLand. Big cases include a 1986 settlement with axx Corp. for over \$43 million made on behalf of some 500 plaintiffs who charged axx with operating an unsafe landfill. His take: \$13 million. Ran unsuccessfully as a Democrat for governor of California in 1974.

3. GERALD MICHAUD

Michaud, Hutton & Bradshaw, Wichita, Kans.
1988 income: \$18 million 1987 income: \$9 million

Age 60. Graduate of Washburn University law school. A leading player in DTP, toxic shock and live polio vaccine cases. Michaud has handled over 500 birth control pill cases since the late 1960s. Recent cases include a \$16 million verdict in 1988 in a toxic shock syndrome case

brought against Playtex International. Michaud's take: \$4 million. In 1988 alone he closed some 20 cases, each of which was worth over \$1 million. Has taken home over \$5 million annually for the last ten years. Owns an 80-acre ranch and 30 quarter horses.

4. WALTER UMPHREY

Umpfrey Swearingen Eddins & Carver, Beaumont, Tex.
1988 income: \$14.5 million 1987 income: \$12.5 million

Umpfrey is 53. Started out as insurance adjuster. Graduated from Baylor University law school; was a pioneer in asbestos litigation. In 1985 he was the leading lawyer in a \$138 million settlement in a class action products liability suit against 16 asbestos firms. Earn-

ings: \$18.2 million. Umpfrey's Beaumont firm made over \$23 million in 1988. His Houston firm recently merged with Houston labor law firm Watson, Flynn & Bensik; and counts among its clients the Oil, Chemical & Atomic Workers Union. Has two planes, a helicopter.

5. MAX TOBEROFF

Toberoff, Teasler & Schochet, New York, N.Y.
1988 income: \$12 million 1987 income: \$6 million

Toberoff, 67, is known as the medical malpractice king of New York, with a specialty in running down podiatrists. Claims to have lost only 6 of the 600 cases he has tried. A ten-week medical malpractice trial in 1988 brought an

\$11.5 million verdict. He boasts that he settled 5 cases over the phone during that trial, for an extra \$15 million. Owns an apartment in Paris worth over \$2 million, and a villa near Cannes. He graduated from Brooklyn Law School.

6. ERNEST CANNON

Ernest Cannon & Associates, Houston, Tex.
1988 income: \$7 million 1987 income: \$11 million



A University of Texas law school grad, Cannon, 45, operates mainly out of Texas' Matagorda County, famous for its multimillion-dollar judgments (FORBES, Apr. 7, 1986). In 1988 Cannon won about \$40 million in gross recoveries, and some \$70 million in 1987. His targets include Ford Motor Co. Also in 1988 he won \$23 million for a 5-year-old client who

was severely injured while riding a lawnmower. Cannon convinced the jury that the manufacturer, Ariens Co., was grossly negligent. Punitive damages in the case were \$13 million. (Ariens subsequently settled.) Known for his close ties to local judges: In one of Cannon's cases a 6-year-old plaintiff sat on the judge's lap to deliver her closing testimony.

7. RONALD D. KRIST

Krist, Gunn, Weller, Neumann & Morris, Houston, Tex.
1988 income: \$9 million 1987 income: \$7.5 million



Best friends with Joe Jamail, Krist won headlines for representing some of the families of the *Challenger* space shuttle astronauts. The amount of the settlement is under seal, but it's in the many millions of dollars. Krist won the

first "crashworthiness" case in Texas against General Motors in 1976. His seven associates pay their own overheads and make whatever they can on their cases. A graduate of the University of Texas law school, Krist is 52.

8. JOHN O'QUINN

O'Quinn, Kerensky & McAninch, Houston, Tex.
1988 income: \$8 million 1987 income: \$6 million



Age 48. Graduated from the University of Houston law school. The State Bar of Texas has just completed an investigation into whether O'Quinn paid people to solicit clients for him. The bar found him guilty, but rather than disbar him, it merely charged O'Quinn a nominal fine for his crime and ordered him to

perform 100 hours of public service. O'Quinn recently won a breach of contract verdict for over \$600 million against Tenneco, which later settled for an undisclosed sum. His fees from this settlement alone will raise O'Quinn's gross income for 1989 to about \$50 million.

9. STANLEY S. SCHWARTZ

Sommers, Schwartz, Silver & Schwartz, Detroit, Mich.
1988 income: \$7 million 1987 income: \$6.2 million



Schwartz, 57, specializes in birth trauma cases. His firm employs 66 lawyers and 100 support staff, and processes over 100 infant brain damage cases a year. These cases yield annual settlements of over \$100 million, of which the

firm takes a third. The firm employs ten nurses full time to evaluate the 60 cases a month that come into his office. A University of Michigan law school graduate, he has written a two-volume, 1,500-page treatise on birth trauma.

10. RICHARD WARREN MITHOFF

Mithoff & Jacks, Houston, Tex.
1988 income: \$7.4 million 1987 income: \$5.4 million



Mithoff is 43, graduated from the University of Texas law school and specializes in product liability and medical malpractice. After working for Ralph Nader as a law student, he spent nine years as a lawyer with Joe Jamail. In 1986 he won a \$50 million settlement from North Texas Hospital for an infant brain damage case. Soon after, Mithoff set up a \$100,000

endowment for the University of Texas medical school to improve training in delivery room techniques. Last year gross recoveries from verdicts and settlements were \$21 million, and the year before, \$16 million. Out of this Mithoff takes 40%. Represented his friend Jamail pro bono in a 1986 contract/fee dispute Jamail had with a referring lawyer.

The Best Paid Trial Lawyers

Lawyer/firm	Location	Estimated 1988 income (\$millions)	Estimated 1987 income (\$millions)	Law school	Age
Gilbert, (Buddy) Low, Organ, Ben & Tucker	Beaumont, TX	8.5	3.5	Univ of Texas	56
Frederic Levin/ Levin, Middlebrooks, Mabie, Thomas, Maves & Mitchell	Pensacola, FL	7.5	5.0	Univ of Florida	52
Philip Corboy/Corboy & Demetrio	Chicago, IL	7.0	5.7	Loyola Univ	63
F. Scott Baldwin/Baldwin & Baldwin	Marshall, TX	6.0	4.0	Univ of Texas	60
Harry Lipsig/Lipsig & Zeiman	New York, NY	6.0	6.0	Brooklyn Law	57
Pat Maloney/Law Offices of Pat Maloney & Associates	San Antonio, TX	6.0	6.0	Univ of Texas	55
Jack Olenick/Law Offices of Jack Olenick & Associates	Washington, DC	6.0	6.0	Univ of Pittsburgh	54
Thomas Demetrio/Corboy & Demetrio	Chicago, IL	5.0	3.8	JT-Chicago Kent College of Law	42
Don Riddle/Riddle & Williams	Houston, TX	5.0	5.0	Univ of Houston	51
Leonard Ring/Leonard Ring & Associates	Chicago, IL	4.8	4.8	De Paul Univ	66
Eugene Pavaon/Pavaon & Gilbert	Chicago, IL	4.5	2.0	Northwestern	56
Sheldon Schlesinger/Sheldon I. Schlesinger	Ft Lauderdale, FL	4.5	4.5	Univ of Miami	59
Guy Allison/Allison & Huerta	Corpus Christi, TX	4.0	4.0	Washington Univ	57
A. Robert Zell/Zell & Zell & Materna	Detroit, MI	4.0	2.1	Univ of Detroit	55
Boo Gibbons/Gibbons & Winkler	Austin, TX	3.7	3.7	Univ of Texas	53
Robert Montgomery Jr/Montgomery & Larmoyeux	W Palm Beach, FL	3.7	3.0	Univ of Florida	59
Ned Good/Law Offices of Ned Good	Pasadena, CA	3.5	3.5	Univ of S Calif	61
Tom Anderson/Thomas T. Anderson & Associates	Indio, CA	3.2	2.5	Univ of San Francisco	61
Robert Conason/Gaur, Gaur & Conason	New York, NY	3.2	2.8	New York Univ	57
Robert Clifford/Robert A. Clifford & Associates	Chicago, IL	3.0	2.3	De Paul Univ	38
Tom Moore/Kramer, Dillos, Tessel, Duffy & Moore	New York, NY	3.0	3.0	Fordham	47
Nat Ozmon/Aces, Ozmon, Lewin & Associates, Ltd.	Chicago, IL	3.0	2.8	Northwestern Univ	64
William Shernoff/Shernoff, Scott & Bidart	Claremont, CA	3.0	3.0	Univ of Wisconsin	51
Don Bowen/Helm, Pletcher, Hogan, Bowen & Saunders	Houston, TX	2.8	2.5	Univ of Texas	45

Law is the only plaintiff attorney in an old-line defense firm. Served as local counsel for various & Sons in ETSI antitrust case against 5 railroads which resulted in a verdict of \$1.3 billion. A 1986 settlement with 4 of the railroads yielded \$235 million. His take: \$12.5 million. He spits his contingency fees with his firm. Represented T. Boone Pickens in 1979 Citrus Service hostile takeover.

Levin earned \$500,000 a year as Citi-Power Co.'s general litigation counsel, 1983-89. Won a \$5 million verdict in one day this May for the death of a young man. His TV show "Law Line" has made him a local celebrity. Counsel for boxer Roy Jones Jr. Member of Inner Circle of Advocates.

Corboy is one of the best-known big-money negligence lawyers in the country. He boasts having lost only one case in 17 years it was overturned on appeal. Turns down 19 out of 20 requests for representation in medical malpractice. Member of Inner Circle of Advocates.

Saidwin started asbestos litigation in U.S. with 1978 case against Pittsburgh Corning, which settled for \$20 million. One of lead counsel in 1987 asbestos case against a dozen companies, which settled for \$125 million. Firm's staff of 15 includes two pilots for his private plane. Member of Inner Circle of Advocates.

Living is considered the "king of torts" in New York. Started new firm earlier this year after split with his two former partners, who claim the firm will now enjoy a more "equitable distribution" of the profits. Currently suing Mike Tyson on behalf of Mitch Greene for \$25 million for assault and battery. Greene is also suing Tyson for "failure to fight." Retires on his long career: "I've wrecked enough lives to feel wrecked myself."

Maloney processes over 1,000 cases a year. Partners are his wife and kids. Active in organizing Texas Supreme Court election campaigns on behalf of the plaintiff bar. Was embroiled in recent scandal involving Texas Supreme Court justice C.L. Ray, in which he donated money to the judge's campaign and received preferential treatment in return. Member of Inner Circle of Advocates.

Oleander is the "king" of medical malpractice in D.C. Mayor Marion Barry declared Feb. 18, 1987 to be "Jack Oleander Day" in recognition of his "humanitarian support" for D.C. city counsel officials. He gave the "Jack Oleander Peacekeeper Award" in 1988 to Corbachev and Rogan. A recent "60 Minutes" special focused on the damage his large verdicts have done to the medical community in D.C. Member of Inner Circle of Advocates.

Demetrie is Philip Corboy's partner and heir apparent. 1989 president of Illinois Trial Lawyers Association. Active in ATLA. He and Corboy have together made at least \$5 million to \$10 million a year in each of the last 8 years.

Rudin has handled over 150 railroad crossing cases, and has lost only one. Won \$6.3 million in 1987 in a medical product liability case, after which plaintiff died. In a separate case he expects to win \$10 million to \$15 million for the family of the deceased client, bringing their total award to about \$20 million. In the second case succeeds his total take will be at least \$6.3 million.

Ring was responsible for setting up the ATLA political action committee in 1973-74. Specializes in precedent-setting cases that expand defendants' liability. Until summer 1989 was chairman of the ATLA committee that proposes and fights legislation in Congress. Chairman of Tort and Insurance Practice Section of the ASA. Member of Inner Circle of Advocates.

Pavison was 1987-88 ATLA president, is current president of the Roscoe Pound Foundation, ATLA's "think tank." Settled a wrongful death auto case against General. Telephone for \$20.3 million in 1988. His take from the case: \$6.7 million.

Schlesinger is one of the biggest medical malpractice specialists in Florida. Won a \$5 million product liability verdict in 1982 against Toyota, arguing that a five-year design defect killed three people in a rear-end collision. It was the only judgment ever won against Toyota. Refers to himself as "Jack the Giant Killer" and "the Socializer." Member of Inner Circle of Advocates.

Alison made more money in a 1988 case against General Motors than GM had paid him in the 25 years he represented it, between 1962 and 1987. Denies medical insurers. Brought case in 1988 against Circle K stores charging them with illegally selling liquor to a drunk "customer." The transactions were staged. Settled case for an undisclosed amount in February. Owns a 4,500-acre cattle ranch near Portland, Tex.

Zett specializes in divorce cases, for which his fees are determined in part by the result obtained. Contingency fees in divorce cases are in violation of ASA rules. Represented Christina Ford, wife of Henry Ford II, in 1980 divorce. Member of Inner Circle of Advocates.

Gibbs is current vice president of ATLA. Settled 1988 legal malpractice case against Vinson & Elkins for "failure to advise" businessmen in antitrust law. Amount of suit: \$3.2 million in damages. Settlement is under gag order. Should make \$5 million in 1989.

Montgomery specializes in medical malpractice. Got the first \$10 million verdict in Florida in a single injury case. Lawyer for Kathleen DuRoi's Ford, widow of Henry Ford II. Split with his former partner Christina Seary (on last over financial disagreements. Member of Inner Circle of Advocates.

Good's boutique firm specializes in aviation and major accidents. Settles 50 cases a year, half of which come in at over \$500,000. Owns and pilots a 7-seat turboprop airplane. Member of Inner Circle of Advocates.

Anderson won a punitive damage verdict of \$147 million in the 1986 Technical Equines fraud case. Some defendants settled previously for \$60 million. The verdict is still pending. Has take so far: \$1 million. Represents 160,000 claimants in a class action fraud suit against evangelist Jim Bakker and associated accounting firm. If successful, he hopes to win \$1,000 for each claimant, or \$160 million. Member of Inner Circle of Advocates.

Quinson is lead counsel in the oldest plaintiff firm in New York, founded by Harry Gaur in 1915. Specializes in medical malpractice. Won \$6.5 million in March of 1989 for family of a client killed by a carefree undercover agent. Member of Inner Circle of Advocates.

Clifford started his career with a 10-year apprenticeship at the Chicago firm of Philip Corboy (also on list). Represents three passengers in the DC-10 Sioux City airplane crash of July 1989.

Moore has taken on the mantle of recently deceased firm founder, Charles Kramer, one of founders of medical malpractice in New York. Recently won a \$2.5 million legal malpractice judgment against another medical malpractice lawyer. Member of the Inner Circle of Advocates.

Orrison is a major architect of the Structural Work Act of Illinois, an act that expands liability claim rights for construction workers.

Sherrod specializes in "insurance bad faith law." Won \$4.5 million verdict over a \$46 disputed medical claim. Helped found with Ralph Nader the National Insurance Consumer Organization. Obtained a \$56 million refund for doctors who claimed they were overcharged on malpractice premiums. Author of "Payment Refused," a handbook on insurance "bad faith."

Occupational counsel for United Transportation Union. Bowen handles over 400 Federal Employees' Liability Act cases for railroad employees, about 100 of which are in hearing loss litigation. FELA cases produce 45% to 50% of firm's income. Partners on list: George Fletcher and Michael Saunders.

The Best Paid Trial Lawyers

Lawyer/firm	Location	Estimated 1988 income (\$millions)	Estimated 1987 income (\$millions)	Law school	Age
Edward Swartz/Swartz & Swartz	Boston, MA	2.8	2.8	Boston Univ	55
Paul Due/Due, Smith & Casaleiro	Baron Rouge, LA	2.7	2.5	Louisiana State Univ	46
Wayne Fisher/Fisher, Gallagher, Pettit & Lewis	Houston, TX	2.7	2.5	Baylor	51
Melvin Bell/Bell, Bell, Brown, Montrose, Fabbro & Zaccaria	San Francisco, CA	2.5	2.5	Berkeley	52
Frank Branson/Law Offices of Frank L. Branson	Dallas, TX	2.5	2.5	SMU	44
Bill Colson/Colson, Hicks, Elson, Colson & Matthews	Miami, FL	2.5	2.5	Univ of Miami	64
Leonard Decol/Decol & Grimm	Providence, RI	2.5	2.5	Harvard	50
Mike Gallagher/Fisher, Gallagher, Pettit & Lewis	Houston, TX	2.5	2.3	Univ of Texas	50
John Hayes/Hayes & Power	Chicago, IL	2.5	2.5	De Paul Univ	58
Joseph Power Jr/Hayes & Power	Chicago, IL	2.5	2.5	Loyola Univ	56
Michael Saunders/Helm, Fletcher, Hogan, Bowen & Saunders	Houston, TX	2.5	2.3	Harvard	44
Christian Searcy/Searcy Denney Scarola Barnhart & Shipley	W Palm Beach, FL	2.5	2.5	Stetson Univ	41
J.B. Spence/Spence Payne Masterton & Needle	Miami, FL	2.5	2.0	Univ of Miami	56
W. James Kneaser/W. James Kneaser, Attorney at Law	Houston, TX	2.4	2.0	Univ of Texas	69
James Thomas Demos/Demos & Burke	Chicago, IL	2.3	2.3	De Paul Univ	54
James Duffy/Kramer, Dillol, Tessel, Duffy & Moore	New York, NY	2.3	2.3	Brooklyn Law	53
Jim Perone/Perone, Turner & Berry	Houston, TX	2.3	2.3	Univ of Houston	50
Bruce Walkup/Walkup, Shelby, Bastian, Melodia, Kelly, Echeverria & Link	San Francisco, CA	2.3	2.3	Berkeley	75
Albert Huerta/Allison, Huerta, Hastings & Allison	Corpus Christi, TX	2.2	2.2	St. Mary's	45
Windle Tuxley/Law Offices of Windle Tuxley	Dallas, TX	2.2	2.2	SMU	50
Robert Begam/Langerman, Begam, Lewis & Marks	Phoenix, AZ	2.0	2.0	Yale	61
Jim Boccardo/Boccardo Law Firm	San Jose, CA	2.0	2.0	Stanford Univ	76
James Bosworth/Bosworth & Tehan	San Francisco, CA	2.0	2.0	UC Hastings	46
William Edwards/Edwards & Perry	Corpus Christi, TX	2.0	2.0	Univ of Virginia	58
Ted Friedman/Law Offices of Theodore H. Friedman	New York, NY	2.0	2.5	Harvard	55
David Perry/Edwards & Perry	Corpus Christi, TX	2.0	2.0	Univ of Texas	46
Ivan Schneider/Schneider, Kleinick & Weitz	New York, NY	2.0	2.0	Brooklyn Law	57
Harvey Weitz/Schneider, Kleinick & Weitz	New York, NY	2.0	2.0	Brooklyn Law	57
George Fletcher/Helm, Fletcher, Hogan, Bowen & Saunders	Houston, TX	1.8	2.0	Noire Dame	61

Swaine has crusaded against "killer tows" since the mid-1960s. Author of "Tows That Don't Care," "Tows That Kill," "Slaughter By Product." Taken on a few business litigation cases, for which he charges a contingency fee/bounty fee hybrid. Member of Inner Circle of Advocates.

Due specializes in maritime disasters. Won a \$4.5 million settlement in a "wrongful death" case against Dixie Electric Membership Corp.

Fisher traditionally specializes in product design and manufacturing liability cases as well as medical malpractice. He has recently gotten into the lucrative areas of antitrust and asbestos litigation. Former president of the State Bar of Texas. Member of Inner Circle of Advocates.

Bell is the original "king of torts." One of the first lawyers in Valdes after the oil spill, he gathered 400 clients there. He and partner Richard Brown were paid \$5,000 in 1958 for work on behalf of a plaintiff in the Dupont Plaza Hotel fire case who had died several years before the fire.

Stansel was one of the pioneers of the Video Settlement. Brochure, a videotape designed to eliminate negotiation with the defense in settlements. In 1953 won a \$15 million settlement for a brain-damaged lawyer. Member of the Texas Supreme Court rules advisory committee.

Colson was the first to win a verdict against Ford in a Pinto gas tank case in 1975. Won the first million-dollar medical malpractice verdict in the U.S. in 1967. The firm has recently gone into asbestos litigation. Member of Inner Circle of Advocates.

Orcutt has won or settled over 25 sports helmet cases, including one for \$4.2 million in 1983. In 1986 he won a \$20 million "wrongful death" verdict against Goodyear for the family of racecar driver Mark Donohue, who was killed in an accident while going 175 mph. Has handled many "women-related" cases, DES, RUD and the Pill. Currently suing the U.S. Golf Association and Scotland's Royal & Ancient Golf Club for over \$100 million in an antitrust and "slayer of products" case on behalf of Ping golf clubs maker Karsten Manufacturing. Member of Inner Circle of Advocates.

Calabrese is partner of Wayne Fisher. Very active in politics, serves as special counsel to the Texas Senate on product liability. One of the few Republicans in the plaintiff bar. Specializes in chemical plant and oil refinery explosion cases.

Harris won a \$27 million verdict against Syntex in 1985 for a brain damage case. Member of Inner Circle of Advocates.

Powers won \$6.5 million verdict in 1986 case for brain damage to child struck by a car. Claims he has never lost a case. Largest settlement: \$6 million in medical malpractice case in 1984. His take: \$2 million.

Saunders specializes in medical malpractice. In 1988 won a \$16.3 million verdict against two doctors for brain damaged child. Two other doctors, the hospital, and the anesthesia machine manufacturer settled for undisclosed amounts. Partners on list: George Pletcher and Don Bowen.

Searcy specializes in multimillion-dollar baby brain damage cases. Largest verdict: \$10.5 million in 1984.

Spence pioneered million-dollar medical malpractice in Florida. Settled 12 "wrongful death" cases against Arrow Air for a total of \$15 million in 1988. His take: \$6 million. Took 6 months off in 1988 and spent over \$300,000 to fight constitutional amendment that would have put caps on damages. Member of Inner Circle of Advocates.

Kronner works with Joe Iamali in Texas-Pennsylvania litigation as legal and appellate adviser. One of the most prominent high-stakes appellate lawyers, he represents both plaintiffs and defendants in multimillion-dollar personal injury and commercial litigation. Charges on average \$450 to \$500 an hour for debar work, and usually gets 5% to 8% of the final award for plaintiff work.

Dewey specializes in medical malpractice and product liability cases. Won a \$2.7 million award against Navistar International Transportation Corp., formerly International Harvester, for "defectively designed" farm equipment. Member of Inner Circle of Advocates.

Dunn is partner of Tom Moore (on list) and is the other "big winner" in the firm. Specializes in medical malpractice, especially brain damaged baby cases. Firm closed 69 cases representing \$60 million in 1988 and has as much as \$7 million invested in cases at any one time.

Pertus, the king of medical malpractice in Houston, won a \$16.5 million verdict in a brain damage case in 1989, brings in several settlements per year in the \$1 million to \$3 million range.

Former president and founding member of Inner Circle of Advocates. Walking is one of the grandfathers of personal injury litigation in California. Member of Inner Circle of Advocates.

Partner to Guy Allison. Muera specializes in workers' compensation.

Turney is founder and sole owner of one of the largest personal injury firms in the country, with 25 lawyers and a staff of 125. Usually works on cases worth more than \$2 million. High overhead costs keep his personal take down. Lead counsel for plaintiffs steering committee of the Delta 191 crash suit, worth more than \$130 million. Major player in the attempt to make airbags in cars mandatory.

Begins started with Cravath, Swaine & Moore. Specializes in product liability. His 1987 novel "Fireball" was inspired by the 1973 Kingman, Ariz., railroad tank car explosion. As lead counsel in that case, he ultimately settled it for over \$20 million in 1979.

Boccardo won one of the first multimillion-dollar awards for quadriplegia: \$3.6 million in 1970. Successful in real estate, owns ranches and airplanes. Member of Inner Circle of Advocates.

Bontrick started as a clerk for Bruce Walking (also on list) in 1967. In 1988 won "the highest federal judgment ever" for a baby brain damage case at a U.S. Army hospital: \$8.9 million. Also boasts "the biggest brain damage settlement ever": \$8.7 million in 1986. His take: \$2 million.

Edwards was special counsel to the Texas Senate in 1987. Won a \$64.5 million verdict in 1985 in palsy case, settled for \$5 million.

Friedman is the husband of New York State Supreme Court Justice Eve Prentiss. Was tried too, and later, in 1988, acquitted of bribing witnesses to lit in a wrongful death suit against New York City. Inner Circle of Advocates member.

Former president of Texas Trial Lawyers Association. Perry specializes in auto design product liability cases. In 1983 won \$107 million verdict against Ford for death of one person (\$100 million was for punitive damages, which were later reduced to \$12.5 million and ultimately settled).

One of the most successful personal injury litigators in New York. Partner of Harvey Weiss. In 1988 Schneider won a \$40 million verdict for a construction worker who was rendered paraplegic from a fall. Has 6 verdicts in excess of \$10 million.

Partner of Ivan Schneider. Weiss won a \$33.3 million verdict from the City of New York for a child who was rendered quadriplegia on a city playground.

Pletcher is senior partner at the first plaintiff law firm in Houston, started in 1944. Between January 1987 and present the firm closed roughly 700 cases, representing recoveries of approximately \$120 million. Partners on list: Don Bowen and Mike Saunders.



BACKGROUND

The Council of State Governments • 3384 Peachtree Road, N.E. • Atlanta, Georgia 30328 • 404/256-1271

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Medical Malpractice Insurance and Access to Obstetrical Care

Introduction

Problems with medical malpractice insurance for obstetrical providers are threatening to reverse recent gains in infant mortality prevention. In the last five years, awareness of the problem of infant mortality in the United States, and particularly in the South, has risen. Many policymakers and concerned citizens know that too many babies are born too small, too soon, and that too many die before their first birthday. Initial efforts to address the problem at the federal and state level have centered on increasing access to prenatal care for pregnant women since early, high quality prenatal care is the single most effective way to ensure the birth of a healthy baby. However, although financial access for low-income women has improved with recent expansions in Medicaid, access for all pregnant women is being threatened by a shortage of providers available and willing to deliver babies.

Factors behind the Shortage of Obstetrical Providers

- The percentage of ob/gyns who accept Medicaid patients is low and is dropping. Currently, less than 60% accept Medicaid. In 1976, over 63% of ob/gyns accepted Medicaid, while 74% of other physicians serve Medicaid patients.
- The number of family physicians, who are often the sole source of primary care—including obstetrics—in rural areas, is dropping. In 1963, there were 73,000

practicing family physicians nationwide. By 1989, there were fewer than 60,000.

- Many ob/gyns are dropping obstetrics from their practice. In 1982, 80% of the ob/gyns in the south atlantic states and 93% of the ob/gyns in the east south central states practiced obstetrics. By 1989, those percentages had dropped to 72% and 86% respectively.
- The cost of medical liability insurance is rising dramatically. The American College of Obstetricians and Gynecologists found that malpractice costs increased 350% between 1982 and 1988, from an average of \$11,000 to \$37,000. In some metropolitan areas, ob/gyns pay in excess of \$100,000 per year.
- Physicians' fear of being sued is justified. It is more likely than not that at least one malpractice claim will be filed against an obstetrician during his or her career. A 1988 survey done for the American College of Obstetricians and Gynecologists (ACOG) found that 70% of ob/gyns had experienced one or more medical malpractice claims. Fully 25% had experienced three or more claims.

The difficulty in finding an obstetrical provider is particularly acute for women on Medicaid and in rural areas. Physicians decline to participate in Medicaid for many reasons. There is a perception that has not been confirmed by research studies, that poor women sue more.

There is also a perception, which may have a stronger basis in fact, that poor women are more likely to have high risk pregnancies or a poor birth outcome. Excessive paperwork and delays in receiving reimbursement under Medicaid are frequent complaints of participating physicians.

Perhaps the greatest obstacle to increased Medicaid participation is low reimbursement rates. In eight states, including two in the South—Louisiana and Missouri, the cost per delivery of medical malpractice insurance is higher than the reimbursement rate for that delivery under Medicaid. In these states, physicians actually lose money for each pregnant Medicaid patient they see. In many more, the cost per delivery of malpractice insurance is nearly as high as the reimbursement rate. Physicians in these states make much less for services rendered to a Medicaid patient than for those rendered to a patient carrying private insurance.

Physicians who continue to practice obstetrics often chose to limit their practices in an attempt to reduce their risk of being sued and reduce their premiums. Limits include discontinuing care to high risk patients, reducing the number of obstetrical patients, and reducing or discontinuing gynecological surgery. The 1988 ACOG survey found that 27% of ob/gyns reported they had decreased the number of babies they delivered. The survey also showed that the situation has deteriorated over time. Significantly more ob/gyns had made changes in their practice because of the risk of malpractice in 1988 as compared to a similar survey in 1985 (41% vs. 35%).

Similar problems are experienced by family physicians and other obstetrical providers such as certified nurse midwives. Family physicians who include obstetrics in their practice paid an average of \$10,000 in 1988 for malpractice insurance. Those who don't practice obstetrics paid an average of \$5,600. Premium costs for family physicians who included obstetrics in their practice increased 43% between 1987 and 1988, much faster than for those who did not, who faced a 34% increase. While the cost of

coverage may seem low compared to the burden faced by ob/gyns, family physicians deliver far fewer babies, so the cost per delivery of medical malpractice may be very high. A 1988 survey by the American Academy of Family Physicians found that 18% of family physicians had discontinued obstetrics because of liability problems, and an additional 6% had decreased the number or type of obstetrical procedures because of medical liability problems.

In many states, the use of certified nurse midwives is increasing because of the high quality patient care, low cost and improved patient education they provide. Certified nurse midwives face relatively high costs for medical malpractice insurance compared to both their average income and their risk of being sued. Only 6% of certified nurse midwives have ever been sued, and yet insurers charge them the same rates as physicians who accept only low risk patients. This means that with an average annual income of \$33,000, certified nurse midwives pay about 21% of their income for liability coverage. Obstetricians pay an average of 10%. Another problem for certified nurse midwives is that insurers often attach a surcharge on the medical malpractice premiums of physicians who supervise them. Insurers claim that a lawsuit is likely to name the supervising physician as well as the certified nurse midwife, but supervising physician as well as the certified nurse midwife, but the American College of Nurse Midwives argues that the surcharge has no actuarial basis and limits their employment opportunities.

State Tort Reform

States have enacted a variety of tort reform measures in recent years in an attempt to remedy problems with access to care for low income patients, and curb rising malpractice costs. The most common approaches have been:

- Collateral source rules. These govern whether or not evidence can be presented at a trial regarding amounts received by the plaintiff from other sources

such as health or disability insurance, workman's compensation, pensions or Social Security. Some states have required that awards be offset by the amount received from other sources;

- Caps on punitive or noneconomic damages;
- Allowing periodic payments of large damage awards to lessen the impact on the defendant and ensure that plaintiffs don't mismanage lump sums;
- Joint and several liability laws have been changed so that defendants are only responsible for payment of awards in proportion to their fault;
- Ad damnum clause restrictions have been enacted which prohibit the plaintiff's complaint from specifying the amount of damages sought so that pretrial publicity does not damage the defendant's reputation.
- Establishing arbitration with a neutral third party as a cheaper, quicker alternative to the traditional court system resolution of a case.

A number of southern states have enacted reforms in the last three years. The following are examples of reforms enacted in response to shortages of obstetrical care caused by problems with malpractice:

- In 1987, Alabama's legislature enacted a number of reforms, including a cap of \$250,000 in noneconomic damages, a cap of \$1 million in wrongful death damages, periodic payment of damages over 15 years. At that time, the collateral source rule was repealed.
- In 1987, Georgia passed a law capping noneconomic damages at \$250,000 and allowing juries to hear evidence about funds received from collateral sources. Another law shortened the statute of limitations to 10 years for a child under

5 at the time of alleged malpractice, and to 5 years after the occurrence for older children. This law also provided immunity to health care professionals providing voluntary care to indigent patients.

- In 1987, Missouri passed a law providing state funded indemnity for physicians who provide pregnancy-related care to indigent patients through the state tort claims act—the law which allows the state to assume liability for state employees.
- In 1987, Virginia passed the Birth-Related Neurological Injury Compensation Act, which establishes a no-fault system of awarding compensation to victims of oxygen deprivation or mechanical injury that occur during birth.
- In 1988, Florida passed an ambitious malpractice reform bill which established an arbitration system with a \$250,000 cap on noneconomic damages for those who participate, and a \$350,000 cap for those who choose the traditional jury trial. The bill also established a fund to compensate victims of birth-related neurological injuries.
- In 1989, Texas passed a Rural Health Care bill which provides indemnity to any health care provider whose patient load is at least 10% indigent. Obstetricians and emergency room physicians are indemnified for the first \$100,000, and all other physicians who serve 10% indigent patients and participate in specified risk management activities are indemnified for the first \$25,000.
- In 1989, West Virginia passed a law establishing a state insurance system for physicians who provide obstetrical care to Medicaid patients. Participating physicians will contribute a fee for each delivery into the system in exchange for \$1 million in insurance coverage.

The Limits to Tort Reform

In early 1989, the Institute of Medicine (IOM) released a study entitled *Medical Professional Liability and the Delivery of Obstetrical Care*. The IOM study concludes that state efforts to reform the tort system have either failed completely, or have yielded results that are too limited to help resolve the problem for obstetrical providers. Therefore, the IOM recommends that states focus their reform efforts on developing alternatives to the tort system. The three alternative approaches found most promising by the IOM study group were no-fault compensation for certain events, a fault-based administrative system, and the use of private contracts.

- No-fault: compensation systems for certain events can be established legislatively to delineate specific conditions or outcomes due to medical interventions, and establish payments for those conditions without regard to negligence. Conditions other than those included would continue to be dealt with through the tort system. In addition, any disciplinary action for providers would have to be dealt with separately.
- The American Medical Association and 32 medical specialty societies advanced a proposal in 1988 for a new administrative system that would replace the current tort system. A strengthened medical practice board or new agency would be empowered by the legislature to administratively review and rule on claims. Legal representation for potential claimants would be provided. Disciplinary action for providers who have rendered substandard care would be handled by a branch of the new agency.
- The expanded use of private contracts would allow providers and patients to

sign agreements which would govern compensation, or procedures to determine compensation before beginning medical care. No legislation would be required for these contracts. However, patient's rights advocates point out that many patients are not educated consumers of medical care, and many have limited choices of providers.

Conclusion

The shortage of obstetrical providers willing and able to deliver babies is already causing problems for women seeking prenatal care and delivery services, particularly women eligible for Medicaid and those who live in medically underserved areas. In recent years, gains in infant mortality have been eroded, largely because of continued problems for women getting access to comprehensive, high quality prenatal care. Women who do not get adequate prenatal care are twice as likely to have a low birth-weight baby (less than 2500 grams). Low birth-weight is a major cause of infant death.

A major cause of the provider shortage is the high cost or unavailability of medical malpractice insurance, and the fear of being sued. Regardless of the cause, the implications for the health of mothers and infants, and for the fight against infant mortality in the South, is that action is needed. Traditional tort reforms have been partly successful in some states in ensuring the availability of medical malpractice insurance, and in limiting cost increases. However, many states are studying or implementing alternatives to the tort system in recognition of the fact that tort reforms have not stemmed the exodus of obstetrical providers from the field, and some solution is needed to ensure that pregnant women have access to good medical care.

This background paper was prepared by Shelly Gehshan, M.P.P., Deputy Director of the Southern Regional Project on Infant Mortality, 444 North Capitol Street, N.W., #240, Washington, D.C. 20001, 202/624-5897.

The Southern Legislative Conference (SLC) is a non-partisan, non-profit organization for southern state legislators and staff. First organized in 1947, the SLC is a regional component of The Council of State Governments (CSG), a national organization which has represented all levels of state government for more than 50 years. The SLC is headquartered in Atlanta.

SOLVING PROBLEMS WITH MEDICAL MALPRACTICE INSURANCE

by Shelly Gehshan

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In a recent survey of state legislators and maternal and child health directors, problems with medical malpractice insurance for obstetrical providers were found to be the most serious health provider issue facing state policymakers. There is a sense of alarm and frustration among state officials that problems with medical malpractice are causing obstetrical providers to stop delivering babies and the resulting shortage of providers is threatening to reverse progress in infant mortality prevention. Recent efforts to address the problem of infant mortality at the federal and state level have centered on increasing access to prenatal care for pregnant women since early, high quality prenatal care is the single most effective way to ensure the birth of a healthy baby. However, although financial access for low-income women has improved with recent expansions in Medicaid financial access is meaningless if women cannot find obstetrical providers.

Problems with medical malpractice insurance are perceived, defined and experienced differently by those involved. Many trial lawyers define the problem as one of negligence by physicians; tort reform efforts are often opposed by trial lawyers because they feel they erode patients rights to recover damages. Physicians define the problem as one of excessively costly malpractice insurance, damage awards, and legal costs that make it difficult to continue practicing obstetrics; many physicians, although they empathize with patients' problems, also believe patients have unrealistic expectations and hold them accountable for poor outcomes that are "acts of God." Consumers define the problem as one of rising health care costs, difficulties finding physicians who practice obstetrics, and concerns about quality of care; for those who experience medical malpractice, high legal costs and the length of time taken to settle cases are major concerns. State health officials and policymakers face the challenge of designing solutions that will ensure access to obstetrical care for state residents, discipline negligent practitioners, help physicians stay in practice and keep insurance companies from leaving the state.

The shortage of providers is the result of a number of factors which are discussed in detail in the next chapter. Perhaps the most important factor is a decrease in the number of family physicians and obstetricians-gynecologists (ob-gyns) who practice obstetrics due, in part, to the high cost or unavailability of medical malpractice insurance and the fear of being sued.

* Many ob-gyns are dropping obstetrics from their practice. In 1982, 80% of the ob-gyns in the South Atlantic states and 93% of the ob-gyns in the east South central states practiced obstetrics. By 1989, those percentages had dropped to 72% and 86% respectively.¹ Nationally in 1985, 83% of ob-gyns practiced obstetrics.²

* Physicians who continue to practice obstetrics often limit their practices in an attempt to reduce their risk of being sued and reduce their premiums. A 1988 survey by the American College of Obstetricians and Gynecologists (ACOG) found that 27% of ob-gyns had decreased the level of high risk obstetrical care, and 13% had decreased the number of babies they delivered.³

* The cost of medical liability insurance has risen dramatically. ACOG found that malpractice costs increased 350% between 1982 and 1988, from an average of \$11,000 to \$37,000. In some metropolitan areas, ob-gyns pay in excess of \$100,000 per year.⁴ However, medical malpractice insurance costs have stabilized in the last few years in most states.

• Physicians' fear of being sued is justified. It is more likely than not that at least one malpractice claim will be filed against an obstetrician-gynecologist during his or her career. Of all ob-gyns, 70% have experienced one or more medical malpractice claims. Fully 25% have experienced three or more claims.⁵

• The tort system is slow, expensive and inefficient for all involved. A 1987 study found that average claims took more than two years to reach resolution. Some cases took up to 11 years to be resolved. Insurers paid \$800 million to investigate and defend claims in addition to claims payments of \$2.6 billion.⁶ Attorneys' fees for both plaintiff and defendant account for 38% of total expenses in resolving an average claim, compared to only 43% of total expenses going to compensate the victim of injury.⁷

• State tort reforms have had some impact on the cost of malpractice insurance, but little or no effect on access to obstetrical care. Almost every state has passed one or more tort reforms since the 1970s, but the frequency of claims and the size of awards and settlements have continued to increase.⁸ The Institute of Medicine studied the issue and concluded that tort reforms "have not lessened the tort system's negative impact on the delivery of obstetrical care nor have they increased providers' confidence in the system."⁹

Medical Liability Insurance and Medicaid

The difficulty in finding an obstetrical provider is particularly acute for women who receive Medicaid benefits and those in rural areas. One of the greatest obstacles to increased provider participation in Medicaid is low reimbursement rates, especially when considered in relation to reimbursements from private insurers and to the cost of medical malpractice insurance. (See Chapter V for more discussion of Medicaid participation.) A 1988 study found that in eight states, including two in the South—Louisiana and Missouri, the cost per delivery of medical malpractice insurance was higher than the reimbursement rate for that delivery under Medicaid.¹⁰ In these states, physicians actually lost money for each pregnant Medicaid patient they served. In many more states, the reimbursement rates were very close to the cost per delivery for medical malpractice insurance.

Table 4A compares 1990 medical malpractice insurance rates with Medicaid reimbursement rates. The differences in just two years are marked. Only one Southern state, Florida, has medical malpractice costs per delivery that are higher than the Medicaid reimbursement for a normal delivery. Reimbursements have risen in most states in the last two years, while medical malpractice insurance rates have stabilized in some areas. However, it is important to note that medical malpractice costs per delivery are still very high—averaging \$333 across Southern states—and these high costs can result in higher physician charges.

Problems Faced by Other Providers

Problems experienced by ob/gyns are also felt by family physicians and other obstetrical providers such as certified nurse midwives. Family physicians who include obstetrics in their practice paid an average of \$10,000 in 1988 for malpractice insurance. Those who don't practice obstetrics paid an average of \$5,600. Premium costs for family physicians who included obstetrics in their

practice increased 43% between 1987 and 1988, much faster than for those who did not, who faced a 34% increase.¹¹ While the cost of coverage may seem low compared to the burden faced by ob/gyns, family physicians deliver far fewer babies, so the cost per delivery of medical malpractice may be very high. A 1988 survey by the American Academy of Family Physicians found that 18% of family physicians had discontinued obstetrics because of liability problems, and an additional 6% had decreased the number or type of obstetrical procedures because of medical liability problems.¹²

In many states, the use of certified nurse midwives is increasing because of the high quality patient care and improved patient education they provide to low risk patients at low cost. Certified nurse midwives face relatively high costs for medical malpractice insurance compared to both their average income and their risk of being sued. Only 6% of certified nurse midwives have ever been sued, and yet insurers charge them the same rates as physicians who accept only low risk patients. This means that with an average annual income of \$55,000, certified nurse midwives can pay as much as 21% of their income for liability coverage. Obstetrician-gynecologists pay an average of 10%.¹³ Another problem for certified nurse midwives is that insurers often attach a surcharge on the medical malpractice premiums of physicians who supervise them. Nearly half of physicians who supervise one or more certified nurse midwives paid an insurance surcharge in 1987.¹⁴ Insurers claim that a lawsuit is likely to name the supervising physician as well as the certified nurse midwife, but the American College of Nurse Midwives argues that the surcharge has no actuarial basis and limits their employment opportunities.

Insurance Regulation

Regulation of the insurance industry has traditionally been relegated to states. State legislatures establish parameters within which companies may offer their products, and state insurance commissions or boards enforce the laws. State regulation is not intended to restrain inflation in medical malpractice insurance rates. Legislatures give state insurance commissions little or no authority to deny or restrict rate increases, perhaps because the availability of medical malpractice insurance has been a problem; 40 states have physician-owned medical malpractice insurance companies that were formed in response to other insurers pulling out of the market entirely, or pulling out of particular states.¹⁵

As Table 4B shows, nearly half of the states in the South allow insurance companies to file rate increases and use them immediately, unless they exceed a specified percentage increase set by law. Even then, if a company provides documentation that the rate is justified, they can use the new, higher rate. In states that require prior approval for a rate increase, insurance companies must submit proof that rate increases are justified and wait a specified number of days before new rates go into effect. Even with this process, rate increases are seldom denied. Although insurance companies are sometimes blamed for the high cost of medical malpractice, and accused of reaping undue profits, numerous studies have found that variations in insurance prices are not capricious, but are due to the number and size of awards and changes in the overall economy.¹⁶

POSSIBLE STATE ACTION TO SOLVE PROBLEMS WITH MEDICAL MALPRACTICE INSURANCE

1. Encourage obstetrical providers to care for Medicaid-eligible, low income and rural patients by subsidizing their medical malpractice insurance or assuming state liability.
2. Continue current tort reform efforts, and expand efforts to include consideration of alternatives to the tort system.
3. Ensure quality of care for patients by strengthening medical practice boards, and supporting risk management activities.

Encourage Providers to Care for Medicaid-eligible, Low Income and Rural Patients

A number of states concerned about gaps in access to obstetrical care for rural residents, or women eligible for Medicaid, have instituted new systems to subsidize medical malpractice insurance or provide state-funded indemnity for obstetrical providers. One of the first such initiatives began in Montgomery County, Maryland in 1987 when two hospitals stopped performing deliveries of Medicaid patients, leaving only two more to handle approximately 800 deliveries each year. Obstetrician-gynecologists in the area complained of medical malpractice rates that were so high that the Medicaid reimbursement rate would not cover their costs. In addition, physicians felt that the area's Medicaid patients were often at high risk medically or socially, so the exposure to potential problems was great. In conjunction with an insurance company, the County agreed to assume the liability for physicians they recruit under contract to perform deliveries of Medicaid patients at local hospitals.

North Carolina's Legislature passed the Rural Obstetrical Care Incentive in the 1988 session to help alleviate shortages of obstetrical care in rural areas. The bill provided \$240,000 for a one year pilot program to help cover medical malpractice insurance premiums for family physicians and obstetricians practicing in medically underserved rural areas.

In 1989, the Texas Legislature passed a broader initiative as part of an omnibus rural health bill. Cosponsored by Rep. Mike McKinney, a physician, the bill establishes a state-funded indemnity system for any medical practitioner, including nurse practitioners, certified nurse midwives, physicians' assistants, and physicians. To qualify, at least 10% of patient encounters in a year need to be charity care, which includes Medicaid and other publicly funded maternal and child health programs. The program offers medical malpractice premium discounts to qualifying practitioners, and state payment of claims against participating practitioners of up to \$100,000 for obstetrical care and \$25,000 for other medical care. The Omnibus Health Care Rescue Act, H.R. 18, was supported by a broad coalition of legislators, providers and advocates who were concerned about severe access problems in rural Texas. A survey by the Texas Medical Association found that 61% of family and general practitioners had limited or eliminated obstetrics from their practice, and 21% of obstetrician-gynecologists had limited their care to Medicaid and indigent patients.¹⁷

West Virginia's Legislature passed a bill in the 1990 session which authorizes the State Board of Risk and Insurance Management to establish a statewide insurance fund to provide primary medical malpractice insurance to

any medical practitioner who provides obstetrical care to patients eligible for Medicaid. Participating physicians will pay a surcharge for each Medicaid delivery into the insurance fund in exchange for coverage of up to \$1 million per incident. Doctors will also be able to purchase additional insurance up to \$3 million. The intent is to reduce the risk for insurance companies so that insurance premiums for physicians in the state will drop. West Virginia passed this bill in response to a critical provider shortage. Five years ago, there were 300 physicians delivering babies in the state. This year, there are only 80 ob/gyns, 20 family practitioners, and two certified nurse midwives left to attend an estimated 22,000 births. Since nearly half of deliveries in West Virginia in any given year are Medicaid eligible, the plan is likely to aid a large number of the state's obstetrical providers.

Alabama's Legislature will be considering a bill in their next session which would take an entirely different approach. The bill would establish a grant program within the Department of Health for obstetrical providers who locate in rural or medically underserved areas of the state. Grants of up to \$30,000 would be available for physicians who established new practices to help them defray costs of medical malpractice insurance. Over the last ten years, more than half of Alabama's 450 obstetricians and family physicians have stopped practicing obstetrics.¹⁸ It is very difficult for women in rural areas to find an obstetrician. The proposed bill, H. 317, has the support of state maternal and child advocacy groups, state health care providers and a number of influential legislators.

While it is unclear whether state initiatives which establish state indemnity for obstetrical providers will motivate insurance companies to lower their premiums, it is clear that initiatives that subsidize medical malpractice insurance premiums can help family physicians and obstetrician-gynecologists continue practicing obstetrics. In lieu of a more comprehensive solution, states can work with state and national medical and specialty societies, including ACOG, and the American Academy of Family Physicians, hospitals and insurance companies to develop a plan that allows obstetrical providers to extend their services to Medicaid-eligible and indigent patients.

Continue Tort Reform Efforts and Consider Alternatives to the Tort System

States have enacted a variety of tort reform measures in recent years in an attempt to curb rising malpractice costs and numbers of claims. The most common approaches have been:

- Collateral source rules. These govern whether or not evidence can be presented at a trial regarding amounts received by the plaintiff from other sources such as health or disability insurance, workman's compensation, pensions or Social Security. Some states have required that awards be offset by the amount received from other sources;
- Caps on punitive or noneconomic damages;
- Shortening the statute of limitations which govern the period of time within which a person who has sustained an injury can file a claim;
- Allowing periodic payments of large damage awards to lessen the impact on the defendant and ensure that plaintiffs don't mismanage lump sums;

* Joint and several liability laws have been changed so that defendants are only responsible for payment of awards in proportion to their fault;

* Ad damnum clause restrictions have been enacted which prohibit the plaintiff's complaint from specifying the amount of damages sought so that pretrial publicity does not damage the defendant's reputation.

Table 4C shows how far Southern states have progressed in implementing these reforms. Every Southern state except North Carolina has adopted one or more of the reforms regarding attorneys' fees, damages or sources of recovery. In many states, these initiatives have faced legal challenges and have been overturned on the grounds that they unduly restrict consumers' access to the courts, or violate equal protection guarantees. A number of states have also enacted other system-related reforms, including seven Southern states—Arkansas, Georgia, Mississippi, North Carolina, Oklahoma, South Carolina, and Texas—who have instituted penalties for filing frivolous lawsuits. Five Southern states—Alabama, Florida, Georgia, Louisiana, and Virginia—have some form of arbitration available which allows plaintiffs and defendants to settle their case out of court.¹⁹ Since the public is not familiar with alternative dispute resolution systems, states have found they must promote their use through public education efforts.

There is a growing consensus, however, that these traditional tort reforms are not working to resolve access problems. In early 1989, the Institute of Medicine (IOM) released a study entitled Medical Professional Liability and the Delivery of Obstetrical Care. The IOM study concludes that state efforts to reform the tort system have either failed completely, or have yielded results that are too limited to help resolve the problem for obstetrical providers. Therefore, the IOM recommends that states focus their reform efforts on developing alternatives to the tort system. The three alternative approaches found most promising by the IOM study group were:

* No-fault compensation systems; Under a no-fault system, the legislature establishes a board or commission to resolve cases involving specific conditions or outcomes due to medical interventions. The board sets payments for those conditions without regard to negligence. Conditions other than those included would continue to be dealt with through the tort system. In addition, any disciplinary action for providers would have to be dealt with separately. Advantages of a no-fault system would be the reduced cost of settling cases that fit the specified definition, settlement in a much shorter time, and uniform benefits for victims. In addition, physicians and plaintiffs would be spared the pressure of court proceedings, and medical malpractice insurance rates would presumably drop if the no-fault system assumed liability for specified events.

* An administrative system; In 1988, the American Medical Association and 32 medical specialty societies proposed a plan for a new administrative system that would replace the current tort system. A strengthened medical practice board or new agency would be empowered by the legislature to administratively review and rule on claims. Legal representation for potential claimants would be provided. Disciplinary action for providers who have rendered substandard care would be handled by a branch of the new agency. Since this system has never been tried, it is unclear what the costs or advantages would be. Proponents say this system would be fairer and more efficient than the current system.

Critics say that it would place too much regulatory power in the hands of the medical profession, creating potential for conflicts of interest.

* Expanded use of private contracts: This proposal would allow providers and patients to sign agreements which would govern compensation, or procedures to determine compensation before beginning medical care. No legislation would be required for these contracts. However, patients' rights advocates feel this is not a viable alternative because many patients are not educated consumers of medical care, and have limited choices of providers.

Both Virginia and Florida have enacted no-fault systems which establish a neutral panel of physicians to rule on compensation in cases of severe birth-related trauma which result in permanent, substantial physical and mental injury. The definition of injuries covered is extremely narrow and would therefore have the potential to remove only a few cases each year from resolution by the tort system. Both systems guarantee prompt payment for victims of injury over their lifetime. Since Virginia passed its no-fault system in 1987, and Florida in 1988, they are still relatively new and untested. One result is that insurers, who had threatened to stop selling insurance in the state, have remained. Claims filed under the no-fault plan in both states will be paid out of a fund built from initial and subsequent annual assessments of participating physicians, and per-delivery assessments on hospitals.

Tort reforms which limit attorneys' fees, cap noneconomic damages, provide for periodic payment of damages, apportion liability according to fault, and reduce awards by the amount already compensated by other sources have had some success in reducing the cost of resolving medical malpractice claims with the tort system. However, they have not been sufficient to prevent obstetrical providers from leaving the field. Therefore, states should examine the results of their tort reform efforts and consider implementing alternatives which give consumers and physicians a way to resolve cases of alleged medical malpractice outside of the tort system.

Strengthen Mechanisms to Ensure Quality of Care

One of the reasons why state tort reform efforts do not work to resolve problems with access to obstetrical care is that physicians perceive themselves to be vulnerable to lawsuits regardless of negligence. A recent study of medical records and malpractice claims in New York state done by Harvard University found that of all the plaintiffs who sued their doctors, only 20% had actually experienced an injury due to negligence.³⁰ Another study found that 60% of all claims filed against physicians are dismissed without a verdict or payment to the plaintiff.³¹ This points to the fact that consumers often hold physicians accountable for adverse events that are not the result of poor medical practice or negligence. Obstetricians and family physicians faced with high premiums and the potential for large damage awards—only part of which may be covered by their insurance—often choose to discontinue obstetrics.

Although medicine is an imperfect science, medical care is actually delivered with relatively few problems for patients. The Harvard study found that 3.7% of patients experienced injuries during medical treatment, and only about 1/4 of those—or about 1% of those admitted to hospitals—were due to negligence. Another way of stating that is 99% of patients receive competent medical care. Despite the large number of medical malpractice claims

nationwide, the study found that only one in eight patients who suffered an injury due to negligence filed a claim. About 16 times as many patients were injured by negligence as received compensation through the New York tort system. Most incidences of injury due to negligence were minor, and a majority of patients recovered within six months.²²

Risk Management

Physicians, hospitals and insurance companies have responded to the large number of medical malpractice claims, high damage awards and high medical liability costs by instituting a variety of risk management and peer review activities to improve the quality of care and protect themselves from lawsuits by reducing adverse events. Almost all insurance companies that sell medical malpractice policies have voluntary or required participation in risk management activities. These vary greatly, but include providing seminars for new physicians or those with large numbers of claims on using informed consent and communicating with patients, risk analysis surveys and reviews of claims, newsletters on risk management and using professional standards of care, and correspondence courses.²³ Participation in these activities is often encouraged by providing premium discounts to physicians who do so. Physician-owned insurance companies have extensive peer review of claims which can result in insurance surcharges, restrictions in practice, requirements for further training, or denial of insurance coverage for physicians who are found to be negligent.

Risk management activities can result in substantial improvements in patient care and reductions in risk of medical malpractice claims. Harvard University hospitals, who are self-insured, found that their claims resulting from anesthesia-related injuries were large. They assembled a committee of anesthesiologists to develop practice guidelines for their hospitals. Published in 1985, the eight principles or guidelines have been made mandatory in Harvard hospitals and have been widely copied elsewhere. Since 1985, there has not been a single death at their hospitals during the administration of anesthesia and, consequently, insurance premiums have dropped dramatically. ACOG has developed and periodically updated a comprehensive volume of practice standards that can be used as a guide for institutions or individuals involved in risk management evaluations.²⁴

State Regulation of Medical Practice

The traditional mechanisms for regulating the practice of medicine and censuring negligent doctors are state medical practice boards. State boards have a range of options in dealing with a physician who has been found to be negligent: reprimands, admonishments, limitations on narcotics permits or prescriptive authority, restrictions on practice, license suspension and license revocation. Despite their broad authority over physicians in practice, state boards revoke very few licenses in response to cases of negligent medical practice: less severe sanctions, or censures for action unrelated to medical practice, are much more common. A 1985 study found that three-quarters of state board actions involve inappropriate writing of prescriptions and abuse by physicians of drugs or alcohol. Of the remaining quarter, most actions were taken in response to a felony or fraud conviction, and not for incompetent medical practice.²⁵ State boards are hampered in their ability to oversee medical practice by strict rules regarding the burden of evidence required to revoke or suspend a physician's license, a lack of extensive peer review capability needed to properly evaluate cases, and a severe lack of resources that has resulted in backlogs of cases in many states.²⁶

In 1986, Congress passed the Health Care Quality Improvement Act to help states assemble a centralized pool of information about disciplinary actions taken and insurance claims made against physicians. The law established a National Practitioner Data Bank which was funded for the first time in 1989. The Data Bank is intended to centralize information on disciplinary actions taken by state licensing boards, hospitals or other institutions to deny or revoke admitting privileges, and medical malpractice claims paid by insurance companies on behalf of a physician. The intent of the law is to prevent incompetent physicians and other licensed providers from moving from state to state to escape knowledge of prior incidences of negligent medical practice, or other problems.

States need to do everything in their power to ensure that the quality of care delivered by all medical practitioners is competent and appropriate, and that occurrences of medical malpractice are minimized. State medical practice boards must be given the resources, authority and peer review mechanisms to quickly resolve all reported cases of alleged medical negligence, and take the necessary action to censure, train or remove from practice physicians who render substandard care. States can also encourage or support risk management and peer review activities at all state-supported medical institutions to try to reduce incidences of poor medical practice.

Conclusion

A major cause of the obstetrical provider shortage is the high cost or unavailability of medical malpractice insurance, and physicians' fear of being sued. Traditional tort reforms have been partly successful in some states in ensuring the availability of medical malpractice insurance, and in limiting cost increases. However, many states are studying or implementing alternatives to the tort system, and assuming liability or subsidizing insurance premiums for providers of charity care, in recognition of the fact that traditional tort reforms have not stemmed the exodus of obstetrical providers from the field.

TABLE 4A

MEDICAID REIMBURSEMENT RATES COMPARED TO
AVERAGE MEDICAL MALPRACTICE INSURANCE COSTS
1990

STATE	Medicaid Fees for a Normal Delivery (1)	Average Medical Liability Per Delivery (2)
Alabama	\$1000	\$324
Arkansas	750	100*
Delaware	590	280*
D.C.	1084	421
Florida	1000	1040
Georgia	1205	246*
Kentucky	910	219
Louisiana	810	379
Maryland	1194	330
Mississippi	726	256
Missouri	1050	840
N. Carolina	925	166
Oklahoma	750	370*
Puerto Rico	n/a	n/a
S. Carolina	1010	37
Tennessee	725	158
Texas	804	353
Virginia	930	149
Virgin Isls.	n/a	n/a
W. Virginia	950	333

(1) Fees listed are either global fees (including prenatal care, a normal delivery and postpartum care), or reimbursements for 13 prenatal visits, a normal delivery and a risk assessment where required. Source: American College of Obstetricians and Gynecologists and the Southern Regional Project on Infant Mortality.

(2) Average medical liability rates per delivery are based on 165 deliveries per year, the average number reported by ACOG in 1988. Insurance rates used are the average charged by the two insurance companies with the top market share in each state. Rates are for "claims made" policies of \$1 million per occurrence/\$3 million per year for obstetrician-gynecologists. * Rates in these states supplied by St. Paul's Insurance Companies, Minnesota.

Data not available for Puerto Rico and the Virgin Islands.

Source: Southern Regional Project on Infant Mortality 1990 survey of State Insurance Commissioners.

TABLE 4B
STATE REGULATION OF MEDICAL MALPRACTICE INSURANCE

STATE	Type of Regulation ¹	Authority to Deny Rate Increases ²	Hearings Required on Rate Increases ³	Special Programs for OB Providers ⁴
Alabama	PA	Y	N	Proposed
Arkansas	FU	Y	N	N
D.C.	FU	Y	N	N
Delaware	PA	Y	N	N
Florida	FU	Y	N	N
Georgia	FU	Y	N	N
Kentucky	FU	Y	N	N
Louisiana	PA	Y	Y	N
Maryland	PA	Y	Y	Y
Mississippi	PA	Y	N	N
Missouri	FU	N	N	N
N.Carolina	FU	Y	Y	N
Oklahoma	PA	Y	Y	N
Puerto Rico	PA	Y	N	Y
S.Carolina	PA	Y	Y	N
Tennessee	FU	Y	N	N
Texas	PA	Y	N	Y
Virginia	FU	Y	N	N
Virgin Isls.	n/a	n/a	n/a	Y
W.Virginia	PA	Y	Y	Y

Source: Southern Regional Project on Infant Mortality 1990 survey of State Insurance Commissioners.

¹ PA = Prior approval. Insurers must obtain approval from the state insurance commission or board before charging new rates. FU = File and use. Insurers may file rates and begin using new rates immediately or within a specified time period.

² Most state insurance boards have very limited authority to deny rate increases. Commissions generally deny rate increases only when they are not justified by actuarial data or documentation is insufficient.

³ In most states, public hearings can be requested by insurers or are required only if rate increases are denied.

⁴ The Puerto Rican government requires insurers to charge lower rates for Medicaid providers. The Virgin Islands subsidizes medical malpractice insurance for all medical practitioners to the extent they serve indigent patients. See chapter text for details about programs operating or proposed in Alabama, Maryland, Texas and West Virginia.

TABLE 4C

TRADITIONAL TORT REFORMS ENACTED IN SOUTHERN STATES

STATE	Attorney Fee Limits	Collateral Source Rule (1)	Joint & Several Liability (2)	Limits on Damages	Periodic Payment of Damages
AL		Y		Y	Y
AR					Y
DE	Y	Y			Y
FL	Y	Y	Y	Y	Y
GA		Y	Y		
KY		Y	Y		
LA				Y	Y
MD	Y			Y	Y
MS			Y		
MO			Y	Y	Y
NC					
OK	Y				
SC					Y
TN	Y	Y			
TX			Y		
VA				Y	
WV			Y	Y	

(1) Collateral Source Rules govern compensation from sources other than the defendant such as health insurance or workers' compensation, usually by mandating that awards be offset by the amount already received by the plaintiff.

(2) Joint and several liability statutes govern the extent to which a number of defendants are liable for damages. Joint liability means that defendants are equally liable for damages, regardless of fault. Several liability means that defendants are held accountable for damages in proportion to their fault.

Data not available for the District of Columbia, Puerto Rico and the Virgin Islands.

Source: American Medical Association Tort Reform Compendium, 1989

1. Okie, Susan, "Serious Threat to Obstetrical Care Seen," The Washington Post, October 12, 1989.
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3. Opinion Research Corporation, "Professional Liability and its effects: Report of a 1987 Survey of ACOG's Membership," The American College of Obstetricians and Gynecologists, March, 1988, p.11.
4. Ibid.
5. Ibid, p. 14.
6. General Accounting Office, "Medical Malpractice: A Framework for Action," GAO/HRD-87-73, May 20, 1987.
7. Testimony Presented to the Health Subcommittee of the Committee on Ways and Means, U.S. House of Representatives, April 26, 1990, Appendix A. Source: The Rand Corporation.
8. General Accounting Office, "Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms," GAO/HRD-87-21, Government Printing Office, 1987.
9. Rostow, Victoria, editor, "Medical Professional Liability and the Delivery of Obstetrical Care," Institute of Medicine, National Academy Press, 1989, vol. I, p. 131.
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14. Opinion Research Corporation for the American College of Obstetricians and Gynecologists, op. cit., p. 8.
15. Fager, Donald, Testimony Presented to the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, Physician Insurers Association of America, April 26, 1989.

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17. Rosenbaum, Sara, "Medical Liability Victory in Texas," Internal Memorandum, Children's Defense Fund, July 13, 1989.
18. Conversation with Doris Barnett, Director of Family Health Services, Department of Health, Alabama, July, 1990.
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21. General Accounting Office, "Medical Malpractice: Characteristics of Claims Closed in 1984," GAO/ERD-87-55, Gaithersburg, Md, 1987.
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23. Rostow, Victoria, editor, op. cit., vol. I, pp. 219-224.
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25. Dept. of Health and Human Services, "Medical Licensure and Discipline: An Overview," Office of the Inspector General, Boston, Mass., June, 1986.
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Infant Mortality Rates... Improvement in the South

State	1985	1989	% Change
Alabama	12.6	11.3	-6.4%
Arkansas	11.6	8.9	-23.3%
Delaware	12.6	12.3	-2.4%
District of Columbia	20.8	22.5	+8.2%
Florida	11.3	9.8	-13.3%
Georgia	12.7	12.1	-4.7%
Kentucky	11.2	8.6	-23.2%
Louisiana	11.9	11.3	-5.0%
Maryland	11.9	9.1	-23.5%
Mississippi	13.7	10.8	-21.2%
Missouri	10.2	11.4	+11.8%
North Carolina	11.8	11.4	-3.4%
Oklahoma	10.9	9.1	-16.5%
Puerto Rico	14.9	14.3	-4.0%
South Carolina	14.2	12.4	-12.7%
Tennessee	11.4	11.0	-3.5%
Texas	9.8	9.5	-3.1%
Virgin Islands	17.7	N/A	N/A
Virginia	11.5	9.5	-17.4%
West Virginia	10.7	9.2	-14.0%
SOUTH	12.4	11.3	-8.9%
U.S.	10.6	9.5	-10.4%

For more detailed information concerning the infant mortality rates displayed in the chart above, or on programs described in this issue of *Spectra*, contact Cathy McGovern at 202-624-5897. ■

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Southern Legislative Conference
444 North Capitol St., N.W. - Suite 240
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New York Times, April 24, 1984, page A1

IMPLANT INDUSTRY IS FACING CUTBACK BY TOP SUPPLIERS

THREAT TO MEDICAL GEAR

Giants Like Du Pont and Dow
Fear They'll Be Drawn Into
Product Liability Suits

By BARNABY J. FEDER

Big chemical companies and other manufacturers of materials used to make heart valves, artificial blood vessels and other implants have been quietly warning medical equipment companies that they intend to cut off deliveries because of fears of lawsuits.

While the suppliers' new policies have not yet forced important products from the market, medical equipment makers that are scrambling to protect themselves from the impending cutoffs say they are having trouble lining up alternate suppliers. Industry executives and doctors say that the trend could eventually make some life-saving implants hard to come by and have a devastating effect on development of new devices.

About 100 equipment companies have already had supply problems, according to reports received by the Health Industry Manufacturers Association, the equipment makers' Washington-based trade group.

The materials manufacturers, including giants like E. I. du Pont de Nemours and the Dow Chemical Company, are dropping the medical business in response to the high risk of being dragged into lawsuits filed against implant makers by consumers who say they have been injured by defective products. Suppliers have already been named in hundreds of suits involving jaw implants, silicone breast implants and other devices.

Equipment makers say that the litigation that has prompted the suppliers to withdraw has also made it harder to obtain the materials indirectly through distributors or other middlemen. In addition, some equipment companies say electronics companies and other important subcontractors that assemble high-tech components for the most sophisticated implants are increasingly reluctant to take on such business.

"You can see a monster scenario where this gets totally out of hand," said Curtis Holmes, vice president for technology at Wilson Greatbatch Ltd. of Clarence, N.Y., a supplier of lithium batteries for heart pacemakers. Wilson is scrambling for a replacement for the pinch of Du Pont Teflon

Continued From Page A1

uses in each battery. Replacing the Teflon could ultimately cost up to \$20,000 in testing and regulatory earnings and take researchers away from developing products. But that is not what really worries Mr. Holmes.

"What if the lithium companies decide they don't want to sell to us?" he asked. "Or the iodine, stainless steel, titanium producers?"

Despite behind-the-scenes lobbying, equipment makers and medical groups have so far raised little concern in Washington about the trend.

Consumer groups say the chemical companies' moves are simply part of a broader campaign by industry to pressure Congress to limit the resources available in courts for those injured by defective products. But as leading supporter of legislation to overhaul product-liability rules has been convinced that the implant makers' plight is a special case.

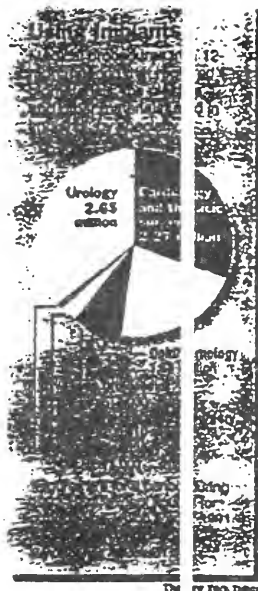
"This is a public health time bomb," said Senator Joseph I. Lieberman, Democrat of Connecticut, who expects to hold hearings on the subject next month. Senator Lieberman said that although the proposed changes in product liability laws would reduce materials suppliers' exposure to lawsuits, the problem might have to be dealt with through specific language in the health care overhaul legislation being written on Capitol Hill.

The medical equipment makers fear that partial protection from litigation will not be enough to bring back the big chemical and plastics suppliers because they have so little to gain from the medical business. Medical devices typically use small quantities of raw materials, compared with other applications.

Polyester yarn, for example, is used in artificial blood vessels, heart valves and sutures left in the body after internal surgery. Total annual sales for such uses are less than \$200,000, a tiny fraction of 1 percent of the \$6 billion market for such yarn in clothing, homes and industry, according to a recent study for the Health Industry Manufacturers Association.

A Drop in the Bucket

Another material being withdrawn from the implant market by Du Pont and Hoechst Celanese is polyacetal resin. The automotive, industrial, plumbing and consumer products sectors buy \$1.3 billion of it annually; the implant industry buys just 550 pounds, valued at \$3,300, for use in heart valves.



Pelletrane, a polyethylene material that began in 1960, is used in the hoses and medical market is so small that Dow realized that company's largest pacemaker manufacturer as a coating on after Dow acquired the Upjohn Company.

In the past, companies have made products like Du Pont polyester, Delrin polytetrafluoroethylene fiber

like Du Pont like Dacron, which is used in the hoses and medical market is so small that Dow realized that company's largest pacemaker manufacturer as a coating on after Dow acquired the Upjohn Company.

In the past, companies have made products like Du Pont polyester, Delrin polytetrafluoroethylene fiber

and resins available to medical companies accompanied by warnings that they had not been tested in any way to establish their suitability for medical applications.

"Everything is manufactured for industrial and consumer purposes," said Katherine Knox, the manager overseeing Du Pont's transition toward cutting off all such sales. "But for 30 years we had a policy that we wouldn't withhold materials from the medical sector because we didn't want to inhibit development."

That policy began to seem foolish after a start-up company in Houston, Vittek Inc., used Teflon to make a jaw

Big companies don't want any blame for misuse of their products.

implant. The device was used by oral surgeons in more than 25,000 patients in the 1980's to treat temporomandibular joint syndrome, which causes pain, clicking sounds in the jaw and restricted jaw movement.

Each Vittek implant used about 5 cents' worth of Teflon. Du Pont played no role in designing or selling the product. But when the implants began to fail, plaintiffs' lawyers, who anticipated that Vittek would soon be swamped by claims, often named Du Pont as a co-defendant.

The plaintiffs, who were seeking compensation for disfigurement, depression, chronic pain and spasms that interfered with activities like eating and talking, have argued that Du Pont knew or should have known that Teflon was unsuited for Vittek's implants and should have refused to supply it. So far, Du Pont has successfully defended all but one suit. It says it is confident of having that jury verdict thrown out on appeal, but its legal costs are running into tens of millions of dollars.

Du Pont told customers in January 1993 that it would stop supplying any materials to implant companies in a year's time. But complaints from customers about difficulties finding alternate suppliers quickly led the company to grant permission for the sale of an extra two years' supply.

Du Pont also agreed to evaluate case by case the problems of any company unable to find alternate suppliers by then. Some may end up paying for more time.

"We've approached more than 15 polyester makers in the United States and Europe, but the best response we've had so far has been a few people willing to give us samples to test with no commitment to supply," said Dennis Gentio, vice president of product surveillance at Medex Medicals Inc., an Oakland, N.J., manufacturer of artificial blood vessels and other vascular grafts made of Du Pont's Dacron. "We are hoping to find an alternate and get it through the regulatory process in time, but I wouldn't say I'm optimistic."

Legal claims totaling billions of dollars have piled up involving faulty breast implants that used silicone made by Dow Corning, which has stopped supplying silicone rubber to most equipment companies.

Dow Corning made silicone breast implants and numerous other devices as well as raw materials for other companies. But as the suits multiplied, basic silicone suppliers with no other connections to the implants, like General Electric and Union Carbide, were also named as defendants.

Consumer advocates like Dr. Sidney Wolfe, the medical affairs spokesman for the Public Citizen Health Research Group, a Washington-based lobbying group, say the litigation is an inevitable result of mis-

guided Federal laws and policies that have allowed most medical implants to reach the public without extensive testing and specific approval from the Food and Drug Administration. The basic law governing medical devices, passed in 1976, allowed equipment makers to market products and introduce new ones without lengthy Government reviews by submitting evidence that they were "substantially similar" to products already sold.

Dr. Wolfe said it made sense to have suppliers joined with the equipment makers in protecting consumers from what he sees as deficiencies in the 1976 act.

"If you sell something, you are in the chain of responsibility," Dr. Wolfe said. Eventually, he said, the lawsuits will lead to the use of better-quality materials in medical equipment.

Suppliers and equipment makers disagree, saying such a policy puts an onerous burden on suppliers to be

deeply involved in the details of customers' products and operations.

"How many questions can a supplier ask without getting into trade secrets?" said John Darnett, a lawyer in Chicago with Kelley, Drye & Warren, whose clients include Union Carbide in the silicone breast-implant litigation. "Not many."

That is not the only problem. Unlike the situation in the drug industry, which is dominated by a few giants, two-thirds of the products developed in the medical equipment area typically come from small companies. Many buy such small amounts of materials that they do not deal directly with big suppliers, making it hard for suppliers to monitor how materials are used.

Some suppliers are wary of continuing dealing with large customers that agree to pay for a costs that might come in litigation, for example, still.

Some suppliers are wary of continuing dealing with large customers that agree to pay for a costs that might come in litigation, for example, still.

In some cases, large, established suppliers will be replaced by smaller operators less likely to be sued.

That seems to be happening in the silicone rubber market. Dow Corning's customers are looking for silicone from the Apex Corporation and News Southern California Corp.

"As far as I know, we're two left in the world," said Winn, chief executive officer, based in Ventura.

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PRACTICE GUIDELINES	CLINTON (S 1737 / IIR 3600)	HOUSE REPUBLICAN (IIR 3080)	CHAFEE (S 1720)	ROWLAND-BILIRAKIS (IIR 3955)	HEALTH SUBCOMTEE WAYS & MEANS Pilot Program	CHIEPER-GRANICH (IIR 3111)
	Pilot Program. Use as an affirmative defense.	No provision	Retainable Presumption for Defense; only overcome by "clear and convincing" evidence.	Complete defense		Study. Guidelines Not linked to Liability
STANDARD OF LIABILITY	No Provision	Reasonableness	No Provision	No Provision	No Provision	Reasonableness
SPECIAL OBSTETRIC PROVISION	No Provision	Liability only upon a showing of "clear and convincing" evidence.	No Provision	Liability only upon a showing of "clear and convincing" evidence.	No Provision	Liability only upon a showing of "clear and convincing" evidence
ALTERNATIVE DISPUTE RESOLUTION	Mandatory, Non-binding	Mandatory, Non-binding. Appeal English rule.	Mediation, at request of any party. Mandatory, non-binding ADR. Appeal English rule.	Mandatory, Non-binding	Funds to States for Demonstration Project	Mandatory, Non-binding Appeal English rule
LIMITS ON ATTORNEY COUNTERCLAIM FEES	1/3 of Award or Settlement	25% of first \$150,000; 10% of Excess	25% of Award or Settlement	35% of first \$100,000; 20% of next \$150,000; 15% of next \$250,000; 10% in excess of \$500,000	33 1/3% of Award or Settlement	35% of first \$150,000; 10% of Excess
NATIONAL PRACTITIONER DATABASE	Public Access	No Provision	No Provision	No Provision	No Provision	No Provision
ENTERPRISE LIABILITY	Demonstration Project	No Provision	No Provision	No Provision	No Provision	No Provision
CERTIFICATE OF MERIT/AFFIDAVIT	Qualified Medical Specialist Opinion Necessary	No Provision	No Provision	Opinion from medical expert on post \$4,000 bond	Qualified Medical Specialist Opinion Necessary	Opinion from medical expert on post \$4,000 bond

COMPARISON OF MEDICAL LIABILITY PROVISIONS IN HEALTH CARE REFORM PLANS

Thomas
H. R. 3704

	CLINTON (S 1757 / H.R. 3600)	HOUSE REPUBLICAN (H.R. 3080)	CHAFEE (S 1770)	ROWLAND-LILIBAKIS (H.R. 3955)	HEALTH SUBCOMTEE WAYS & MEANS	COOPER-RANDY (H.R. 332)
CAP ON NONECONOMIC DAMAGES	No Provision	\$250,000	\$250,000	\$250,000	\$350,000	\$250,000, plus future development of alternative limits
COLLATERAL SOURCE OFFSETS	Mandatory	No Provision	Mandatory	No Provision	Mandatory	No Provision
PERIODIC PAYMENTS	Yes, at the request of any party	Permissive, when damages exceed \$100,000	Permissive, when damages exceed \$100,000	Permissive, when damages exceed \$100,000	Yes, at request of any party	Permissive, when damages exceed \$100,000
PUNITIVE DAMAGES	No Provision	100% Paid to State	75% Paid to State	As to Manufacturers Only: 50% Paid to State; No more than 2x all other damages.	No Provision	100% Paid to State
STATUTES OF LIMITATIONS-ADULTS	No Provision	7 Years from Injury	2 Years from Discovery; 6 Years from Occurrence	2 Years from Discovery	No Provision	2 Years from Discovery
STATUTES OF LIMITATIONS-MINORS	No Provision	No Provision	Minors under 6 may file any time before they turn 12	Minors under 6 may file any time before they turn 8	No Provision	Minors under 6 may file any time before they turn 8
REVISION OF JOINT AND SEVERAL LIABILITY TO PROPORTIONAL LIABILITY	No Provision	For All Damages	For noneconomic and punitive damages only	For noneconomic damages only	No Provision	For noneconomic damages only

APPENDIX 2.—MATERIAL FOR THE HEARING RECORD**STATEMENT FOR THE HEARING RECORD
OF THE AMERICAN BAR ASSOCIATION**

Submitted to the Subcommittee on Economic and Commercial Law
House Committee on the Judiciary
on H.R. 3600 Health Security Act
July 15, 1994

The American Bar Association respectfully submits the following views concerning the proposed revision to section 507 of title 11, United States Code as set forth in H.R. 3600 Health Security Act. The proposed legislation would give priority status to any "payments under subtitle B of title IV of the Health Security Act owed to a regional alliance (as defined in section 1302 of such Act)," "payments owed to a corporate alliance health plan under trusteeship of the Secretary of Labor under section 1395 of the Health Security Act" and "assessments and related amounts owed to the Secretary of Labor under section 1397 of the Health Security Act." Section 5234 of H.R. 3600 Health Security Act ("Section 5234"). For the reasons more fully set forth herein, the American Bar Association is opposed to such revision.

The proposed legislation would give certain claims related to the Health Security Act priority in payment to other unsecured claims in a bankruptcy case. Although it is recognized that the legislature desires to develop a strong national health insurance system, giving these claims priority in bankruptcy will only deteriorate the effectiveness of the bankruptcy reorganization process.

The American Bar Association has adopted blanket authority to oppose any proposed priorities to the United States Bankruptcy Code, except under exceptional circumstances. None of the proposed priorities under Section 5234 are warranted by the presence of exceptional circumstances and therefore, if enacted would not advance the important underlying principals upon which the American bankruptcy system is predicated.

One of the most important principals of the American bankruptcy system is equal treatment of creditors. Upon the filing of a bankruptcy petition, all actions to collect debts from the debtor are stayed so that a debtor can concentrate on a plan for reorganization. This stay also prevents a "race to the courthouse" by creditors who would otherwise attempt to attach the debtor's property before any other creditor. The result of a race is that certain creditors would receive a distribution on their claim, while other creditors, for no justifiable reason, would not. This important and powerful element of the American bankruptcy system is reduced by the addition of priorities, which give persons, who are otherwise general unsecured creditors, priority in payment to other creditors similarly situated. In a sense, priorities produce the same result as a "race to the courthouse," that is, unequal distribution to creditors, sometimes for no justifiable reason.

Although the current Bankruptcy Code contains certain carefully chosen priorities, the success of the American bankruptcy system can be credited in part, to the fact that the system is relatively free of priorities. Recent developments in International Insolvency Law serve as a lesson when amendments to the United States Bankruptcy Code are considered. For example, the recent proposal for revision of the German bankruptcy system attempts to make Germany's system more similar to the United States bankruptcy system especially as to limitations placed upon priorities. Upon unification, Germany sought to revise its bankruptcy system, which allowed broad categories of debts to receive preferential status including: a) claims of employees and other labor costs; b) fiscal or government claims; c) clerical claims or claims of churches, etc.; d) claims of medical doctors, veterinarians, surgeons, pharmacists, etc.; and e) claims for children. Hans-Jochem Lüer, Hans-Gerd Jauch, Foreign and Multinational Business Insolvency in Germany, The Third National Institute of Multinational Commercial Insolvency (1993). There is little doubt that each and every one of these priorities viewed individually are worthy of preferred treatment. However, the cumulative effect of these priorities was to deny other worthy creditors a distribution on their claims. The draftsmen of the new German Insolvency Code found that the preferential treatment was arbitrary and without justification, and therefore abolished all preferential claims, so that now, all unsecured creditors will rank equally as a class. See Stefan Reinhart, Germany's Insolvency Bill, Vol 2., International Insolvency Review, 29, 35 (1993). "The experience in Europe and elsewhere has been that engrafting welfare priorities into the reorganization process had destroyed the process. Chapter 11 is the envy of most nations because it works; it works in large part because priorities are limited and parties are compelled to negotiate." Hearing Before the Subcomm. on Monopolies and Commercial Law to Consider H.R. 2962, 100th Cong., 1st Sess. 160 (1987) (testimony of Nathan B. Feinstein.)

If every special interest is given priority in bankruptcy, other non-priority unsecured creditors, which more often than not are trade creditors who are vital to a debtor's continued existence, will have no desire or reason to participate in the bankruptcy process. Once a large network of priority claims is established, which includes claims that tend to be unusually large, such as taxes and health care claims, the general unsecured creditors will understand from the first day of the reorganization that there is no hope for any distribution to them. Not only will unsecured creditors be unwilling to help the debtor through the reorganization, but they will be unlikely to continue to work with a company that is on the verge of bankruptcy. This will certainly decrease the number of successful reorganizations.

The establishment of more priorities will not only decrease the willingness of unsecured creditors to deal with a debtor or a potential debtor, but it will erode confidence in the American bankruptcy system. It is also important to realize that unsecured creditors can also consist of claims of, for example, workers injured by exposure to asbestos as in the Manville bankruptcy case and women who were injured by defective intrauterine devices as in the A.H. Robbins bankruptcy case. Further, unsecured claims are often held by small business that depend on a distribution on their claim for the very survival of their business. As the late 1980's filing numbers reflect, many more Americans have been touched by the bankruptcy system. Although it has become more acceptable to file for bankruptcy, the belief still exists

that bankruptcy is a way to wipe out debts at the expense of the "little people," which are usually general unsecured creditors. By way of further example, a "60 Minutes" story on bankruptcy was recently re-broadcast, showing the ability of executives of large companies, who have filed bankruptcy to retain possession of large estates. Although that story focused on the bankruptcy exemption laws, it is evidence of the fact that the confidence in the American bankruptcy system is being eroded. With the expansion of priorities, it is more likely that the "little people" will not receive a distribution in a bankruptcy case. This will certainly facilitate the erosion of any confidence that remains in the system.

As more priorities are established, a point will be reached where the system will be completely changed from one of cooperation and negotiation between certain interests, which must cooperate in order to reap the benefits of a reorganized debtor, to one of hopelessness due to the unlikely event that unsecured creditors will receive a distribution in the bankruptcy case. This certainly will hinder the use of the reorganizational process. This has happened in England. "In England . . . there has been the growth of the 'floating charge' under which banks or similar institutions take possession of all of an insolvent debtor's assets and proceed to liquidate or reorganize outside of the bankruptcy process, generally without significant judicial supervision. In France, and indeed in most other countries, reorganization is rare unless by the substantial infusion of governmental moneys." Hearing Before the Subcomm. on Monopolies and Commerical Law to Consider H.R. 2969, 100th Cong., 1st Sess. 169 (1987) (testimony of Nathan B. Feinstein.)

There is no obvious reason why corporate alliances should be preferred over other unsecured creditors who, for example, must be encouraged by the debtor to continue supplying post-petition services and supplies to the debtor. The guarantee provided by Section 1396 of the Health Security Act ensures that a corporate alliance can continue to operate, despite the bankruptcy of a member of the Alliance. Although the Federal Government certainly would like the Fund to be reimbursed, in full, as part of the reorganization plan, such payment could only be made at the expense of the general unsecured creditors. The results of this preferential treatment, as previously discussed, are not justified when the Secretary of Labor has the ability to set assessments on all corporate alliance health plans in order to ensure the solvency of the Fund. (Section 1397 of the Health Security Act). Through assessments, the costs of a member's bankruptcy can be spread over a larger number of entities, rather than placing the entire burden on the unsecured creditors of the debtor.

Although it is clear that no entity enjoys paying for another's misfortune, it is also clear that if a company were not afforded a chance to reorganize, the loss of the company could cause far more economic demise than the cost of its rehabilitation. The goal of reorganization is to help the debtor through rough times so that everyone can reap the benefits in the future. Even in a liquidation, the equality and fairness of the distribution scheme is essential to the public's faith in our bankruptcy system. The expansion of priorities significantly decreases the chance that everyone will be entitled to reap the benefits, rather, it ensures that certain parties, deemed to be more important by the legislature, will reap more than their fair share, at the expense of the others.

GEORGE W. GEKAS
17TH DISTRICT PENNSYLVANIA

COMMITTEE ON THE JUDICIARY

SUBCOMMITTEES

ADMINISTRATIVE LAW AND GOVERNMENTAL
RELATIONS—RANKING MEMBER

CRIME AND CRIMINAL JUSTICE

ELECT COMMITTEE ON INTELLIGENCE



Congress of the United States
House of Representatives
Washington, DC 20515-3817

TESTIMONY

by

The Honorable George W. Gekas

before the

House Judiciary Subcommittee on Economic and Commercial Law's

hearing on

"MALPRACTICE LIABILITY REFORM"

Mr. Chairman, I join my colleagues on the House Committee on the Judiciary in thanking you for holding this hearing, since health system reform will be incomplete without inclusion of provisions to reform our medical malpractice liability system.

Malpractice liability costs -- which include the direct costs of insurance, litigation, and settlements and the indirect costs of defensive medicine -- play a significant role in the rapid growth of health care spending. The costs associated with medical liability have increased more rapidly than any other component of physician practice costs. The costs of defensive medical practice and of litigation related to health care disputes have had a substantial impact on the affordability and availability of quality medical care.

In 1991, total American tort costs were \$132 billion, or 2.3 percent of Gross Domestic Product (GDP). These direct costs included payments to plaintiffs, costs of defending suits in court, and administrative overhead. Since 1980 real tort costs have increased 7 percent annually while real GDP has risen only 2.4 percent per year.

In 1991, medical malpractice torts comprised almost 7 percent of total direct tort costs, or \$9.1 billion. This number excludes indirect costs such as those due to defensive medicine. Physician-associated suits comprised 58 percent of these costs, 28 percent were associated with hospitals, and 14 percent were designated as other.

Real malpractice tort costs increased from \$0.9 billion in 1974 to \$9.2 billion in 1991, for an average annual growth rate of 15 percent, roughly one and one half times the growth rate of all torts. Even total health-care expenditures only grew at an 11 percent annual rate during this period.

The first wave of malpractice reform emerged from the malpractice insurance crisis of the early 1970s. Responding to malpractice insurance premium increases of 410 percent between 1970 and 1975, a 42 percent

REF: 1-1-1-1

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increase in the frequency of claims and a 264 percent increase in the average award size in the same time period, Indiana signed into law the Medical Malpractice Act of 1975, one of the most far-reaching such reforms enacted to date in the U.S.

This Indiana act capped total damages at \$500,000, limited physicians' liability to \$100,000, capped legal contingency fees at 15% for awards over \$100,000, established mandatory medical review panels, and established the Patient's Compensation Fund. It also established a statute of limitations, mechanisms for reporting and reviewing claims, rules for periodic payments, and a residual malpractice insurance authority. In 1990, the \$500,000 cap was raised to \$750,000 for claims originating in 1990 or later. The reforms have been upheld by Indiana courts.

A second flurry of tort reform swept across the nation in the middle 1980s, after another episode of skyrocketing malpractice insurance rates. States adopted caps on noneconomic damages (15 states do this, with eight (8) states having caps on total damages), reformed collateral source rules (19 states require mandatory offsets of collateral sources and eleven (11) states admit evidence of collateral sources but leave offsets to the discretion of the court), and revised joint and several liability. Fourteen (14) states mandate periodic payment of large damage awards, generally starting at \$100,000, and sixteen (16) leave it to the court's discretion.

Almost all states now restrict the statute of limitations to three (3) years from the date of injury or discovery. Eight (8) states have sliding scales for attorney fees, and five (5) have flat maximums. Indiana's is the most restrictive, with a 15 percent cap on fees for all awards greater than \$100,000. Fifteen (15) states have adopted arbitration provisions specific to medical malpractice. Thirty (30) states restrict punitive damages, and thirty-three (33) have revised or abolished joint and several liability.

The controversial nature of caps has led to numerous challenges in state courts, on the grounds that they violate due process, equal protection, separation of powers, and right to trial by jury. Courts have upheld caps in several states and struck them down in several others. Opponents have also challenged medical review panels. The Indiana court ruled that the review panels did not cause added delays in the litigation process and the mandatory admissibility of the panel's verdict did not violate the separation of powers.

States -- especially California, Indiana, and Mississippi -- are way ahead of the federal government on malpractice reform.

I have both cosponsored and introduced legislation containing provisions to reform the medical liability system. Both bills -- the House Republican Task Force bill (H.R. 3080, Minority Leader Michel's Action Now Health Care Reform Act) and the Gekas bill (H.R. 191, the American Consumers' Health Care Reform Act) -- would enhance medical liability management and quality assurance and enact tort reform, such as limiting non-economic damages and using alternative dispute resolution (ADR) systems.

Malpractice liability reform in and of itself is insufficient as a response to the problems in the U.S. health care system. Malpractice reform must be accompanied by tax reform. Necessary tax changes include the right of individuals to receive the same health insurance premium tax treatment as do employers as well as the right of consumers to utilize "medical savings accounts" to have an incentive be cost conscious in the

health care market.

With regard to anti-malpractice reform forces, it is necessary in terms of honesty to remind interested parties that more deaths in this country come from malpractice (90,000) than car accidents (40,000). Therefore, malpractice must deal not only with the costs -- direct and indirect -- of malpractice claims, but also with the incidence of malpractice itself. Malpractice reform must include steps not only to reform the direct and indirect costs of tort liability, but also steps to empower consumers with information about providers, including public disclosure of the Health Practitioners Data Bank. Public disclosure has been included in legislation I introduced in 1992; ACHRA includes a provision to require states to collect and publish outcomes data of hospitals and insurers.

Federal malpractice reform is necessary, since many states, including Pennsylvania, refuse to reform their medical tort liability systems. Pennsylvania's only malpractice reform is a non-binding arbitration panel. However, federal reform should not preempt more restrictive state malpractice systems.

An important justification for malpractice reform is something called "negative defensive medicine," in which the high cost of malpractice insurance decreases the number of insured doctors, thereby decreasing access and quality. For example, since 1/2 of Florida surgeons can't afford liability insurance, injured patients will not be able to recover their medical costs and lost wages (economic damages). Florida patients also have less access to quality Ob-Gyn and neurosurgeon services, so an unstable malpractice environment cuts the number of providers and quality of their health care services.

As far as my past action on this issue, in 1992 I helped pass a bill which was signed into law by former President Bush. The "Federally Supported Health Centers Assistance Act" included workers at federally-funded community clinics under the Federal Torts Claims Act, which pays for government claims. I helped pass this bill by offering a "budget neutral" amendment -- later adopted -- which would require HHS to give the Justice Department funds to cover claims against clinic workers. Clinics should have benefited from this in the amount of about \$100 million over three years.

President Clinton has decided not to place a cap on malpractice awards, but has instead proposed a watered-down plan with 2 main features:

1. Clinton's first provision is to institute what lawyers call the "collateral source rule," which requires them to seek payment first from a client's own insurance policy and attempt to recover from the doctor's malpractice policy only if the client's policy does not cover the damages; and,
2. The other main feature is a cap on attorney's fees. This cap, however, does not limit fees to Indiana's generous 15%, or even 25%. Showing much more generosity to attorneys than he has shown the taxpayers, the president will cap attorneys' fees at 33%. Since market studies show that 33% is the typical fee for most contingent arrangements, Clinton's cap should have very little effect in reducing the costs of health care and malpractice insurance.
3. The White House Health Care Task Force once publicly proposed an enterprise liability rule. This would exempt individual physicians from paying for malpractice awards. The responsibility would be

transferred to the hospital or other health care organization where the physician practices. Clinton has since dropped enterprise liability from his bill.

Public Citizen, a pro-government Democrat group, criticizes the Clinton plan as doing nothing to prevent and punish medical malpractice.

Moving to my own Commonwealth of Pennsylvania, the Commonwealth's medical liability system costs far too much and takes too long to resolve claims; provides exorbitant awards to some patients, while not providing fair compensation to others; encourages the practice of defensive medicine; and threatens access to health care in certain specialties (e.g., obstetrics), particularly for rural or other medically underserved areas of the state. The following strategies will improve timely and fair claim adjudication, enhance predictability in premiums and insurability of risks, reduce costs associated with defensive medicine and the tort system, and improve risk management. These strategies, supported by the Hospital Association of Pennsylvania, include:

- (1) the establishment of caps for non-economic damages to ensure reasonable compensation and predictable awards for pain and suffering, disability and disfigurement, loss of consortium, mental anguish, emotional distress, psychic injuries, and loss of society;
- (2) the payment of punitive damages for egregious behavior to the Catastrophic Insurance Fund, rather than to an individual claimant;
- (3) a direct offset of all collateral sources of payment received by a plaintiff, except for Social Security and life insurance;
- (4) limitation of attorneys' fees in medical liability cases to assure that damages awarded in a case accrue to the benefit of the plaintiff and to reduce the incentive for pursuit of frivolous lawsuits;
- (5) the use of periodic payments or structured settlements for future damages to ensure that payments to plaintiffs for future needs are accrued in a cost-effective manner;
- (6) the abolition of the rule of joint and several liability to ensure that defendants bear a judgement in proportion to their culpability;
- (7) the evaluation of new alternative dispute resolution mechanisms for the Commonwealth as an alternative to the state's current ineffective non-mandatory, non-binding arbitration panel system;
- (8) the establishment of time frames for the production of medical expert testimony following the filing of a medical malpractice claim and a requirement that standards be established requiring that experts be qualified in the same field as the defendant; and,
- (9) an evaluation of the appropriateness of the concept of "enterprise liability" under health care reform where care is rendered through integrated networks.

Without malpractice reform, our health care system will not have been reformed. Once again, I thank the chair and pledge to work with him in this regard.

* * *

**STATEMENT FOR THE HEARING RECORD
OF THE NATIONAL BANKRUPTCY CONFERENCE**

Submitted to the Subcommittee on
Economic and Commercial Law
House Committee on the Judiciary
on H.R. 3600, Health Security Act
June 29, 1994

Re: Bankruptcy-Related Concepts
in the Clinton Health Security
Legislative Proposal

The National Bankruptcy Conference* respectfully
submits the following views about two bankruptcy-related
concepts included in S. 1757/H.R. 3600, the Health Security

*The National Bankruptcy Conference is a non-profit, voluntary association of about 65 judges, professors and practicing attorneys from all parts of the United States. Its members are selected for demonstrated professional and technical excellence in the field of bankruptcy law. The Conference was founded in the middle 1930s to promote the improvement of the bankruptcy laws and their administration. The Conference, which meets twice a year, has been consistently active in the legislative process. It assisted and advised Congress in drafting the Chandler Act of 1938 and played major roles in the enactment of the current Bankruptcy Code in 1978 and the amendment process ever since. (See, e.g., 6/29/84 Congressional Record, S-8888) (Senator Thurmond describes the NBC's role in compromise leading to enactment of § 1113 of the Code regarding rejection of collective bargaining agreements).

The NBC has no staff, paid or unpaid, and operates on a budget of approximately \$40,000 per year of cash contributions from members plus various "in kind" expenditures by members for the NBC's benefit (e.g., plane fares of members, photocopy, etc.).

Act ("HSA"). Copies of the two provisions we discuss are attached.

I. Summary of NBC Position

<u>TOPIC</u>	<u>POSITION</u>	<u>REASON</u>
New priority status for amounts due to regional alliances, corporate alliances and the health fund guaranty corporation	Opposed	Priorities distort fair distributions in bankruptcy cases and impair public confidence in the integrity of the federal insolvency laws.
Secretary of Labor as trustee for insolvent corporate health alliances	Support, except when the corporate alliance has liabilities for borrowed money, leases, etc. in excess of \$1,000,000, in which case insolvency should be administered under the Bankruptcy Code	In cases where health claimants are the only creditors, the federal government guaranties payments of their benefits. There will therefore be no creditor loss, and use of the Bankruptcy Code is unnecessary. In other cases, however, the Bankruptcy Code should be used.

TOPIC	POSITION	REASON
Jurisdiction of the federal courts over Secretary of Labor trusteeships	Opposed	The language in § 1395(f) is so overbroad that it could sweep jurisdiction over employer business failures into the proceedings for the employer's insolvent health plan.

II. § 5234 -- Proposed New
Priority in Bankruptcy Cases

NBC Position: Opposed

Reason: Unwarranted deviation from historic, strong policy of equal treatment of creditors

The public gets furious when official policy in insolvency cases is unfair and not even-handed. Special, favorable treatment for targeted groups means they get paid in full and other groups, unfavored, receive little or nothing. This is as or more unpopular and unwise in insolvency laws than "special breaks" in tax statutes. Deviation from fair distribution in bankruptcy cases thus destroys public confidence in the insolvency process, thereby chilling, to a measurable degree, creditor willingness to accept risk. This in turn deters economic growth.

Much experience over the decades in America and around the world supports and confirms the point made in the preceding paragraph.

Section 5234 of HSA would amend Section 507(a)(8) of the Bankruptcy Code to deviate from fair and even-handed treatment of creditors by:

- (1) giving a priority to certain Medicare amounts due regional alliances;
- (2) giving a priority for certain amounts owed to insolvent corporate alliances; and
- (3) giving a priority to assessments due to a new, FDIC-like entity, which will guarantee self-insured health plans of large corporations.

The creation of all these priorities is wrongheaded. For instance, consider No. 2 above. Suppose hypothetical Metal Bender Inc., of MidAmerica, Wisconsin, an old company, having 40,000 blue collar workers and 60,000 retirees, all receiving medical care at Metal Bender's expense under Metal Bender's "corporate alliance" (the new name for its same-old health plan), is forced into Chapter 11. Suppose also that its health plan is insolvent. Priority No. 2 above could draw away so much of the operating company's working capital that it might not have enough cash to (i) make pension-funding contributions that are required by other federal laws or (ii) worse, keep operating. This shutdown would cost the economy 40,000 jobs.

This is often the unanticipated, undesired effect of uncontrolled, unlimited priorities in bankruptcy.

Moreover, at least one of the proposed new priorities is unneeded, because existing Section 507(a)(4) already creates a carefully defined priority for amounts due to employee benefit plans. This was carefully thought out in the enactment of the 1978 Code and we believe it should be adequate for purposes of HSA.

Accordingly, we believe § 5234 should be deleted in its entirety from any health bill enacted by the Congress.

III. § 1395 -- Trusteeships of the Secretary of Labor

NBC Position: Not opposed in concept but the NBC does oppose (i) its use when there are \$1,000,000 or more in creditors other than health claimants and (ii) certain provisions on judicial jurisdiction

Reason: Section 1395 follows roughly the model of FDIC receivership of failed banks; this seems reasonable, given federal guaranty of health-coverage costs. However, where liabilities to persons other than health claimants, such as landlords and lenders, exceed a de minimis amount, then the protection of the Bankruptcy Code should be invoked. The language needs clarification to prevent health plan trusteeships from superseding the availability of Chapter 11 for the employer.

Under HSA, a "corporate alliance" is the new statutory name for self-insured health plans offered to employees and their families by business entities with 5,000 or more employees, in the aggregate. Some of these plans

are offered by single employers (e.g., General Motors); others have multiple employers acting together under the aegis of union contracts. The HSA would allow these types of plans to continue, under new regulations, whereas smaller employers or groups with less than 5,000 employees would have to disband their plans and purchase insurance through regional alliances.

To protect workers from insolvency of corporate alliances, the HSA creates a Corporate Alliance Health Plan Insolvency Fund (§ 1396(c)) designed to play the same role for health plans that the FDIC plays for banks. That is, the employers pay assessments to build up an insurance fund and the fund can be drawn on to cover the liabilities of insolvent plans (§ 1397). It would appear from § 1396 that, in effect, the full faith and credit of the United States stands behind the obligations of these plans to health claimants. See § 1396(a). This is consistent with the universal coverage objectives of HSA.

Section 1395 provides that the Secretary of Labor shall be appointed by the appropriate U.S. District Court* as the trustee for a corporate-alliance health plan if it "will be unable to provide benefits when due or is otherwise in a financially hazardous condition".

*See § 1395(f)(2).

When the only creditors are health claimants, it does not seem to us to be sensible to provide for the administration of these insolvent plans under the Bankruptcy Code, for two reasons: (1) the Code does not now cover domestic insurers (see 11 U.S.C. § 109(b)(2)) and does not contain any provisions whose application has ever been thought out or applied in the context of a defunct insurance obligor; and (2) given the evident liability of the United States to guaranty and pay all liabilities of the insolvent plan, it does not seem likely that any creditors will suffer any loss. It follows that the protections of the Bankruptcy Code for creditors in the public are not called for.

However, when the corporate alliance has other significant liabilities, not guaranteed by the federal government, we believe the alliance's insolvency should be administered under the federal Bankruptcy Code. We suggest that the threshold for application of the Bankruptcy Code be \$1,000,000 or more in probable liabilities to claimants other than health claimants. The foregoing is needed because the applicable provisions of HSA do not address a host of issues involved in a proceeding under the Bankruptcy Code, such as pro rata distribution, voidable preference, fraudulent transfer, entitlement to vote on plans of reorganization, dischargeability of debt, etc.

With regard to § 1395(f) ("Jurisdiction of Court"), we see all manner of possibility for un-needed

litigation expense and confusion in the case of large, industrial business failures.

For instance, § 1395(f) says that upon approval of the filing of an application to appoint the Labor Secretary as trustee for a corporate alliance health plan, the district court shall "stay . . . any pending . . . proceeding to reorganize . . . the sponsoring alliance". Additional language gives other powers over the "sponsoring alliance" and its property to the health-plan district court.

We find no definition of the term "sponsoring alliance". One logical construction we would fear is that "sponsoring alliance" means the sponsoring employer. If this be the case, then HSA would supersede Chapter 11 and prevent use thereof to reorganize large enterprises in the United States! This would occur, for instance, if the Secretary was made the trustee of the corporate health plan. The court would then (arguably) be required to enjoin the sponsoring employer from filing a Chapter 11 petition.

This cannot be the Congressional intent.

A second possible definition of "sponsoring alliance" would be the case of a multi-employer corporate alliance where "sponsoring alliance" would not obviously mean "sponsoring employer". Even in this context, we see no policy justification for giving to the health-plan court broad power over other property of the sponsoring alliance.

Also, if the employer is (despite the foregoing) actually in Chapter 11 and the health plan is in a trusteeship, we see regrettable possibility for clashing courts. There could easily be a life-tenured District Judge running the employee health-plan case in one judicial district and a non-tenured bankruptcy judge running the Chapter 11 for the employer in another district, possibly in another circuit. Who will have what authority over the Chapter 11 case?

Given the authority over the sponsoring alliance and its property conferred on the district court in § 1394(f), will great expense, uncertainty and delay so "gum up" the employer Chapter 11 case that successful rehabilitation might be threatened?

We see the foregoing as a real danger and suggest resolving the scope-of-jurisdiction problem by adding language to § 1395(f) such as the following:

"Nothing in the provisions of this subsection (f) and no order of any court hereunder shall be in derogation of the right of any eligible person to seek relief under Title 11 U.S. Code or in derogation of the jurisdiction of any court administering any case under Title 11 U.S. Code. In case of any conflict of jurisdiction between this Title and Title 11, U.S. Code, Title 11 jurisdiction shall prevail."

Also, we suggest that language be added to § 109 of the Bankruptcy Code making it clear that no corporate alliance health plan or regional alliance as defined in HSA is eligible to be a debtor under Title 11, U.S. Code, except

if it has \$1,000,000 or more in debts to entities other than health claimants.

This will all keep future "Hatfield" health plan cases separated from future "McCoy" employer Chapter 11 cases, all to the good of reduced expense and faster legal proceedings generally.

Please address any questions to the NBC's Vice-chair of legislation, Stephen Case, at 202-962-7140 (Suite 1200 East, 1300 I Street, N.W., Washington, D.C. 20005).
Thank you.

NATIONAL BANKRUPTCY CONFERENCE

Attachment

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13 **SEC. 5234. PRIORITY OF CERTAIN BANKRUPTCY CLAIMS.**

14 Section 507(a)(8) of title 11, United States Code, is
15 amended to read as follows:

16 “(8) Eighth, allowed unsecured claims—

17 “(A) based upon any commitment by the
18 debtor to the Federal Deposit Insurance Cor-
19 poration, the Resolution Trust Corporation, the
20 Director of the Office of Thrift Supervision, the
21 Comptroller of the Currency, or the Board of
22 Governors of the Federal Reserve System, or
23 their predecessors or successors, to maintain
24 the capital of an insured depository institution;

25 “(B) for payments under subtitle B of title
26 IV of the Health Security Act owed to a re-

1 gional alliance (as defined in section 1301 of
2 such Act);

3 “(C) for payments owed to a corporate alli-
4 ance health plan under trusteeship of the Sec-
5 retary of Labor under section 1395 of the
6 Health Security Act; or

7 “(D) for assessments and related amounts
8 owed to the Secretary of Labor under section
9 1397 of the Health Security Act.”.

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6 SEC. 1395. TRUSTEESHIP BY THE SECRETARY OF INSOL-
7 VENT CORPORATE ALLIANCE HEALTH PLANS.

8 (a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR
9 INSOLVENT PLANS.—Whenever the Secretary of Labor
10 determines that a corporate alliance health plan which is
11 a self-insured plan will be unable to provide benefits when
12 due or is otherwise in a financially hazardous condition
13 as defined in regulations of the Secretary, the Secretary
14 shall, upon notice to the plan, apply to the appropriate
15 United States district court for appointment of the Sec-
16 retary as trustee to administer the plan for the duration
17 of the insolvency. The plan may appear as a party and
18 other interested persons may intervene in the proceedings
19 at the discretion of the court. The court shall appoint the
20 Secretary trustee if the court determines that the trustee-
21 ship is necessary to protect the interests of the enrolled
22 individuals or health care providers or to avoid any unrea-
23 sonable deterioration of the financial condition of the plan
24 or any unreasonable increase in the liability of the Cor-
25 porate Alliance Health Plan Insolvency Fund. The trustee-

1 ship of the Secretary shall continue until the conditions
2 described in the first sentence of this subsection are rem-
3 edied or the plan is terminated.

4 (b) POWERS AS TRUSTEE.—The Secretary of Labor,
5 upon appointment as trustee under subsection (a), shall
6 have the power—

7 (1) to do any act authorized by the plan, this
8 Act, or other applicable provisions of law to be done
9 by the plan administrator or any trustee of the plan,

10 (2) to require the transfer of all (or any part)
11 of the assets and records of the plan to the Sec-
12 retary as trustee,

13 (3) to invest any assets of the plan which the
14 Secretary holds in accordance with the provisions of
15 the plan, regulations of the Secretary, and applicable
16 provisions of law,

17 (4) to do such other acts as the Secretary
18 deems necessary to continue operation of the plan
19 without increasing the potential liability of the Cor-
20 porate Alliance Health Plan Insolvency Fund, if
21 such acts may be done under the provisions of the
22 plan,

23 (5) to require the corporate alliance, the plan
24 administrator, any contributing employer, and any
25 employee organization representing covered individ-

1 uals to furnish any information with respect to the
2 plan which the Secretary as trustee may reasonably
3 need in order to administer the plan,

4 (6) to collect for the plan any amounts due the
5 plan and to recover reasonable expenses of the trust-
6 eeship,

7 (7) to commence, prosecute, or defend on behalf
8 of the plan any suit or proceeding involving the plan,

9 (8) to issue, publish, or file such notices, state-
10 ments, and reports as may be required under regula-
11 tions of the Secretary or by any order of the court,

12 (9) to terminate the plan and liquidate the plan
13 assets in accordance with applicable provisions of
14 this Act and other provisions of law, to restore the
15 plan to the responsibility of the corporate alliance,
16 or to continue the trusteeship,

17 (10) to provide for the enrollment of individuals
18 covered under the plan in an appropriate regional al-
19 liance health plan, and

20 (11) to do such other acts as may be necessary
21 to comply with this Act or any order of the court
22 and to protect the interests of enrolled individuals
23 and health care providers.

1 (c) NOTICE OF APPOINTMENT.—As soon as prac-
2 ticable after the Secretary's appointment as trustee, the
3 Secretary shall give notice of such appointment to—

4 (1) the plan administrator,

5 (2) each enrolled individual,

6 (3) each employer who may be liable for con-
7 tributions to the plan, and

8 (4) each employee organization which, for pur-
9 poses of collective bargaining, represents enrolled in-
10 dividuals.

11 (d) ADDITIONAL DUTIES.—Except to the extent in-
12 consistent with the provisions of this Act or part 4 of sub-
13 title B of title I of the Employee Retirement Income Secu-
14 rity Act of 1974, or as may be otherwise ordered by the
15 court, the Secretary of Labor, upon appointment as trust-
16 ee under this section, shall be subject to the same duties
17 as those of a trustee under section 704 of title 11, United
18 States Code, and shall have the duties of a fiduciary for
19 purposes of such part 4.

20 (e) OTHER PROCEEDINGS.—An application by the
21 Secretary of Labor under this subsection may be filed not-
22 withstanding the pendency in the same or any other court
23 of any bankruptcy, mortgage foreclosure, or equity receiv-
24 ership proceeding, or any proceeding to reorganize, con-

1 serve, or liquidate such plan or its property, or any pro-
2 ceeding to enforce a lien against property of the plan.

3 (f) JURISDICTION OF COURT.—

4 (1) IN GENERAL.—Upon the filing of an appli-
5 cation for the appointment as trustee or the issuance
6 of a decree under this subsection, the court to which
7 the application is made shall have exclusive jurisdic-
8 tion of the plan involved and its property wherever
9 located with the powers, to the extent consistent
10 with the purposes of this subsection, of a court of
11 the United States having jurisdiction over cases
12 under chapter 11 of title 11, United States Code.
13 Pending an adjudication under this section such
14 court shall stay, and upon appointment by it of the
15 Secretary of Labor as trustee, such court shall con-
16 tinue the stay of, any pending mortgage foreclosure,
17 equity receivership, or other proceeding to reorga-
18 nize, conserve, or liquidate the plan, the sponsoring
19 alliance, or property of such plan or alliance, and
20 any other suit against any receiver, conservator, or
21 trustee of the plan, the sponsoring alliance, or prop-
22 erty of the plan or alliance. Pending such adjudica-
23 tion and upon the appointment by it of the Sec-
24 retary as trustee, the court may stay any proceeding
25 to enforce a lien against property of the plan or the

sponsoring alliance or any other suit against the plan or the alliance.

(2) VENUE.—An action under this subsection may be brought in the judicial district where the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

(g) PERSONNEL.—In accordance with regulations of the Secretary of Labor, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

**SEC. 1396. GUARANTEED BENEFITS UNDER TRUSTEESHIP
OF THE SECRETARY.**

(a) IN GENERAL.—Subject to subsection (b), the Secretary of Labor shall guarantee the payment of all benefits under a corporate alliance health plan which is a self-insured plan while such plan is under the Secretary's trusteeship under section 1395.

(b) LIMITATIONS.—Any increase in the amount of benefits under the plan resulting from a plan amendment which was made, or became effective, whichever is later, within 180 days (or such other reasonable time as may be prescribed in regulations of the Secretary of Labor) be-

1 fore the date of the Secretary's appointment as trustee
 2 of the plan shall be disregarded for purposes of determin-
 3 ing the guarantee under this section.

4 (c) CORPORATE ALLIANCE HEALTH PLAN INSOL-
 5 VENCY FUND.—

6 (1) ESTABLISHMENT.—The Secretary of Labor
 7 shall establish a Corporate Alliance Health Plan In-
 8 solvency Fund (hereinafter in this part referred to
 9 as the "Fund") from which the Secretary shall au-
 10 thorize payment of all guaranteed benefits under
 11 this section.

12 (2) RECEIPTS AND DISBURSEMENTS.—

13 (A) RECEIPTS.—The Fund shall be cred-
 14 ited with—

15 (i) funds borrowed under paragraph

16 (3),

17 (ii) assessments collected under sec-
 18 tion 1397, and

19 (iii) earnings on investment of the
 20 Fund.

21 (B) DISBURSEMENTS.—The Fund shall be
 22 available—

23 (i) for making such payments as the
 24 Secretary of Labor determines are nec

1 essary to pay benefits guaranteed under
2 this section,

3 (ii) to repay the Secretary of the
4 Treasury such sums as may be borrowed
5 (together with interest thereon) under
6 paragraph (3), and

7 (iii) to pay the operational and admin-
8 istrative expenses of the Fund.

9 (3) BORROWING AUTHORITY.—At the direction
10 of the Secretary of Labor, the Fund may, to the ex-
11 tent necessary to carry out the purposes of para-
12 graph (1), issue to the Secretary of the Treasury
13 notes or other obligations, in such forms and de-
14 nominations, bearing such maturities, and subject to
15 such terms and conditions as may be prescribed by
16 the Secretary of the Treasury. The total balance of
17 the Fund obligations outstanding at any time shall
18 not exceed \$500,000,000. Such notes or other obli-
19 gations shall bear interest at a rate determined by
20 the Secretary of the Treasury, taking into consider-
21 ation the current average market yield on outstand-
22 ing marketable obligations of the United States of
23 comparable maturities during the month preceding
24 the issuance of such notes or other obligations by
25 the Fund. The Secretary of the Treasury shall pur-

1 chase any notes or other obligations issued by the
2 Fund under this paragraph, and for that purpose
3 the Secretary of the Treasury may use as a public
4 debt transaction the proceeds from the sale of any
5 securities issued under chapter 31 of title 31, United
6 States Code and the purposes for which securities
7 may be issued under such chapter are extended to
8 include any purchase of such notes and obligations.
9 The Secretary of the Treasury may at any time sell
10 any of the notes or other obligations acquired by
11 such Secretary under this paragraph. All redemp-
12 tions, purchases, and sales by the Secretary of the
13 Treasury of such notes or other obligations shall be
14 treated as public debt transactions of the United
15 States.

16 (4) INVESTMENT AUTHORITY.—Whenever the
17 Secretary of Labor determines that the moneys of
18 the Fund are in excess of current needs, such Sec-
19 retary may request the investment of such amounts
20 as such Secretary determines advisable by the Sec-
21 retary of the Treasury in obligations issued or guar-
22 anteed by the United States, but, until all borrow-
23 ings under paragraph (3) have been repaid, the obli-
24 gations in which such excess moneys are investe

1 may not yield a rate of return in excess of the rate
2 of interest payable on such borrowings.

3 **SEC. 1397. IMPOSITION AND COLLECTION OF PERIODIC AS-**
4 **SESSMENTS ON SELF-INSURED CORPORATE**
5 **ALLIANCE PLANS.**

6 (a) **IMPOSITION OF ASSESSMENTS.**—Upon a deter-
7 mination that additional receipts to the Fund are nec-
8 essary in order to enable the Fund to repay amounts bor-
9 rowed by the Fund under section 1396(c)(3) while main-
10 taining a balance sufficient to ensure the solvency of the
11 Fund, the Secretary of Labor may impose assessments
12 under this section. The Secretary shall prescribe from time
13 to time such schedules of assessment rates and bases for
14 the application of such rates as may be necessary to pro-
15 vide for such repayments.

16 (b) **UNIFORMITY OF ASSESSMENTS.**—The assess-
17 ment rates so prescribed by the Secretary for any period
18 shall be uniform for all plans, except that the Secretary
19 may vary the amount of such assessments by category,
20 or waive the application of such assessments by category,
21 taking into account differences in the financial solvency
22 of, and financial reserves maintained by, plans in each cat-
23 egory.

24 (c) **LIMITATION ON AMOUNT OF ASSESSMENT.**—The
25 total amount assessed against a corporate alliance health

1 plan under this section during a year may not exceed 2
2 percent of the total premiums paid to the plan with respect
3 to corporate alliance eligible individuals enrolled with the
4 plan during the year.

5 (d) PAYMENT OF ASSESSMENTS.—

6 (1) OBLIGATION TO PAY.—The designated
7 payor of each plan shall pay the assessments im-
8 posed by the Secretary of Labor under this section
9 with respect to that plan when they are due. Assess-
10 ments under this section are payable at the time,
11 and on an estimated, advance, or other basis, as de-
12 termined by the Secretary. Assessments shall con-
13 tinue to accrue until the plan's assets are distributed
14 pursuant to a termination procedure or the Sec-
15 retary is appointed to serve as trustee of the plan
16 under section 1395.

17 (2) LATE PAYMENT CHARGES AND INTEREST.—

18 (A) LATE PAYMENT CHARGES.—If any as-
19 sessment is not paid when it is due, the Sec-
20 retary of Labor may assess a late payment
21 charge of not more than 100 percent of the as-
22 sessment payment which was not timely paid.

23 (B) WAIVERS.—Subparagraph (A) shall
24 not apply to any assessment payment made
25 within 60 days after the date on which payment

1 is due, if before such date, the designated payor
2 obtains a waiver from the Secretary of Labor
3 based upon a showing of substantial hardship
4 arising from the timely payment of the assess-
5 ment. The Secretary may grant a waiver under
6 this subparagraph upon application made by
7 the designated payor, but the Secretary may
8 not grant a waiver if it appears that the des-
9 ignated payor will be unable to pay the assess-
10 ment within 60 days after the date on which it
11 is due.

12 (C) INTEREST.—If any assessment is not
13 paid by the last date prescribed for a payment,
14 interest on the amount of such assessment at
15 the rate imposed under section 6601(a) of the
16 Internal Revenue Code of 1986 shall be paid
17 for the period from such last date to the date
18 paid.

19 (e) CIVIL ACTION UPON NONPAYMENT.—If any des-
20 ignated payor fails to pay an assessment when due, the
21 Secretary of Labor may bring a civil action in any district
22 court of the United States within the jurisdiction of which
23 the plan assets are located, the plan is administered, or
24 in which a defendant resides or is found, for the recovery
25 of the amount of the unpaid assessment, any late payment

1 charge, and interest, and process may be served in any
2 other district. The district courts of the United States
3 shall have jurisdiction over actions brought under this sub-
4 section by the Secretary without regard to the amount in
5 controversy.

6 (f) **GUARANTEE HELD HARMLESS.**—The Secretary
7 of Labor shall not cease to guarantee benefits on account
8 of the failure of a designated payor to pay any assessment
9 when due.

10 (g) **DESIGNATED PAYOR DEFINED.**—

11 (1) **IN GENERAL.**—For purposes of this section,
12 the term “designated payor” means—

13 (A) the employer or plan administrator in
14 any case in which the eligible sponsor of the
15 corporate alliance health plan is described in
16 subparagraph (A) of section 1311(b)(1); and

17 (B) the contributing employers or the plan
18 administrator in any case in which the eligible
19 sponsor of the corporate alliance is described in
20 subparagraph (B) or (C) of section 1311(b)(1).

21 (2) **CONTROLLED GROUPS.**—If an employer is a
22 member of a controlled group, each member of such
23 group shall be jointly and severally liable for any as-
24 sessments required to be paid by such employer. For
25 purposes of the preceding sentence, the term “con-

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1 trolled group" means any group treated as a single
2 employer under subsection (b), (c), (m), or (o) of
3 section 414 of the Internal Revenue Code of 1986.

CAP ■ MPT

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TESTIMONY OF ROBERT A. REID, M.D.
FOR THE JUDICIARY SUBCOMMITTEE ON
ECONOMIC AND COMMERCIAL LAW
UNITED STATES HOUSE OF REPRESENTATIVES
ON H.R.3600, HEALTH SECURITY ACT
MEDICAL MALPRACTICE ISSUES

JUNE 22, 1994

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to make this statement. My name is Robert A. Reid, M.D. I am an obstetrician and gynecologist, and I have been in private practice in Santa Barbara, California since 1971. I graduated from the University of Colorado, School of Medicine in 1965 and obtained my specialty training at the University of Colorado Medical Center. I served as President of the Santa Barbara County Medical Society in 1982 and as Chief of Staff of Santa Barbara Cottage Hospital from 1988 until 1990. I now serve on the Board of Directors of Santa Barbara Cottage Hospital. I served on the California Medical Association Board of Trustees from 1982 to 1990 and am currently Speaker of the California Medical Association House of Delegates. I am a member of the Board of Directors of the Cooperative of American Physicians/Mutual Protection Trust (CAP/MPT).

CAP/MPT, an interindemnity trust founded by and for physicians, has provided professional liability protection for qualified California physicians since 1977. The 4,000-plus member CAP/MPT was formed as an alternative to traditional malpractice insurance during the height of the medical malpractice crisis of the mid-1970s. Member physicians share financial responsibility for the professional liability claims against fellow members.

On behalf of the Cooperative of American Physicians/Mutual Protection Trust and myself, I am pleased to have the opportunity to offer this statement regarding the need for effective liability reform as a necessary component of health care reform. Our primary concern is that no federal health care plan preempt existing California laws on medical malpractice reform.

Even without federal pre-emption of state medical malpractice laws, if there is federal action which is weaker than California laws, it will nonetheless influence and tend to push California toward the federal model. Therefore, CAP/MPT would prefer federal enactment of MICRA rather than adoption of half measures at the federal level. Health care reform should include liability provisions that contain two very important components, caps on non-economic damages and limits on attorneys' fees. Enactment of any medical liability reform as part of a federal health care plan without these components will not be fully effective as California's Medical Injury Compensation Reform Act of 1975 (MICRA).

As a California doctor, I think I bring a unique perspective to your deliberations. California is home to one of the most comprehensive medical liability laws in the nation -- the Medical Injury Compensation Reform Act of 1975 -- commonly known as MICRA. These laws were passed in response to a medical malpractice insurance crisis. In 1975, due to a dramatic increase in both the number of suits filed and the magnitude of awards, malpractice insurance rates skyrocketed 300 to 400 percent. Many physicians were forced to close their doors as they were unable to buy insurance.

Before MICRA, California's medical malpractice insurance premiums were the highest in the nation. Today, they are one-third to one-half the price of premiums paid by health care providers in other states. The five essential provisions of MICRA are:

- (1) A limit on non-economic damages of \$250,000. Economic damages such as past and future medical expenses, lost wages, and retirement benefits, have no limit.

- (2) A limit on contingency fees, so that the bulk of the award in malpractice lawsuits goes to the plaintiff, not the lawyers. The scale limits lawyers' fees to 40 percent of the first \$50,000, 33 1/3 percent of the next \$50,000, 25 percent of the next \$500,000, and 15 percent of any amount exceeding \$600,000.
- (3) Waiver of the collateral source rule. A jury can be informed of any other benefits a plaintiff is collecting such as workers' compensation, disability insurance or health insurance.
- (4) Periodic payments of future damages over \$50,000.
- (5) A statute of limitations identical to the one advocated in the federal reform proposal.

WHAT DID THE PASSAGE OF MICRA ACHIEVE?

- (1) Stability for the medical liability system that ensures there is a pool of money available to pay legitimate claims of malpractice.
- (2) Lower malpractice rates for doctors and thus lower health care costs for Californians -- although consumer costs in California were generally higher than the national average in 1991, the state's medical care services index was lower. Just as a basis of comparison, the average California Ob/Gyn pays approximately \$40,000 annually for medical liability coverage. This compares with \$142,000 for the Michigan Ob/Gyn, \$131,000 for the Florida Ob/Gyn, and \$100,000 for the New York Ob/Gyn. Michigan, Florida, and New York have all failed to enact MICRA-

like reforms.

- (3) Access to care -- because of MICRA's liability protections, health care providers are more willing to provide high-risk care and treat high-risk patients.
- (4) Reduced litigation costs -- because of MICRA, grievances are resolved quickly and more responsively for the patient. Out-of-court settlements as well as alternative dispute resolution by binding arbitration are encouraged under MICRA, rather than drawn-out jury trials.

I am here to define the medical liability problem, urge you to strongly consider MICRA-like reforms as the solution, and encourage the inclusion of MICRA's components in the national health care reform package.

The United States has the world's most expensive tort system. Tort costs are substantially higher than any country. The U.S. tort system costs \$132 billion in 1992. Between 1933 and 1991, tort costs rose by a factor of almost 400, while U.S. economic output (GNP) grew only one hundredfold.

Despite this magnitude of spending, our tort system functions very poorly in meeting its objectives of compensating injured parties and improving safety by deterring careless or wrongful behavior.

Americans want reform, both in our tort system and in our health care system.

Americans strongly support effective medical liability reform as a component of health system reform. In a Gallup poll, 77 percent of Americans cited malpractice lawsuits and awards as an important factor in rising health care costs. The consensus is: The current tort system, without modification, is unable to resolve liability claims cost-effectively and makes a haphazard contribution to deterring negligent behavior or improving the safety of health care. Action at the federal level is needed to bring normalcy to a medical liability system gone awry. Here's why:

Liability is a major factor influencing access, quality and cost of health care in the United States. Medical liability insurance premiums rose from \$1.7 billion in 1982 to \$5.6 billion in 1989, and are even higher today.

Defensive medicine must be considered in estimating system-wide medical malpractice costs. Defensive medicine is carried out by physicians and medical institutions to avoid malpractice claims. In a 1992 Gallup poll of general practice physicians, 93 percent said that fear of lawsuits causes them to prescribe diagnostic tests that were otherwise unnecessary. According to a Lewin-VHI report, comprehensive medical liability reform as a component of health care reform could save an estimated \$35.8 billion over the next five years by curbing defensive medicine practices and premium costs.

The more the federal government regulates health care, the more important it is to regulate liability.

If health care benefits, delivery, and costs are mandated by federal government, but liability exposure is different among the 50 states, these differences will cause gross inequities in different regions of the country.

New federal mandates will generate new liability exposure. Physicians and health care providers who have contracted with mandated alliances will be under economic pressure to make decisions to deny care, which will create a climate generating additional liability.

It is important to stress that although federal involvement is crucial to solving the medical liability crisis, it should not be at the expense of states that have already enacted strong medical liability reform, such as California. Federal law should not preempt stronger state laws -- it should instead serve as a floor to establish uniformity and equality, reserving for the states the right to establish more forceful reforms.

The major objectives of health care liability reform are as follows:

- (1) Any meaningful reform of the liability system must contain meaningful patient safeguards against malpractice or harm from medical products or services.
- (2) The system's focus should be compensation of injured patients. People injured in the course of receiving health care treatment are entitled to fair and prompt compensation. No one disputes this. Unfortunately, the current tort system has failed the patient population. While our system ostensibly is designed to compensate the injured, the RAND Corporation estimates that only 43 cents of

every dollar spent on medical liability and litigation reaches patients.

- (3) The patient/provider relationship should be strengthened, not impeded. The current liability system creates an overall climate of fear and suspicion that impedes the maintenance of trusting therapeutic relationships.
- (4) The liability component of health care costs should be contained. All patients bear the burden of the high health care liability costs paid by potential defendants, when their costs are passed on in the form of more expensive health care services. Liability insurance premiums are a significant contributing factor to the growth in patients' health care bills. Defensive medicine has added to the cost of health care. In 1989, it was estimated that the practice of defensive medicine added an additional \$15.1 billion to the costs of health care. The number is even higher today.
- (5) Access to comprehensive health care should be promoted. Increasing premiums and the threat of liability have caused physicians and health care providers to abandon practices and to cease providing certain services in various areas of the country.

There has been a broad diversity of experimentation among the states with regard to liability reform. There are, in fact, fifty different systems in place for resolving disputes over medical negligence. The question is, which of the fifty systems has been the most successful in achieving the following purposes of a medical liability system?

To fairly and adequately compensate people who have been injured through medical negligence.

To nurture adherence to the high professional standards among health care professionals.

To maintain affordable coverage for medical liability so that every provider secures coverage which will create an adequate insurance reserve to compensate valid claims.

To provide incentives for individual responsibility at a level which will motivate all health care providers to take reasonable steps to reduce risks of injury and protect the safety of patients.

We believe the answer is MICRA, it works for Californians, and it can work for health care consumers all across America. If the Judiciary Committee does not adopt MICRA, we respectfully urge that it leave these matters to the states where they have traditionally remained. I appreciate the opportunity to present this statement to the Committee and I invite your questions and comments. Thank you for your consideration.

VENABLE, BAETJER, HOWARD & CIVILETTI
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July 21, 1994

Chairman Jack Brooks
Committee on the Judiciary
House of Representatives

Dear Mr. Chairman:

I had hoped to to have the opportunity to testify before the Subcommittee on Economic and Commercial Law on behalf of G.D. Searle & Co. and the Pharmaceutical Research and Manufacturers of America with regard to what I believe are the significant and adverse effects of Section 2003(e) of the Health Security Act, H.R. 3600. I believe that this "anti-discount" provision could radically and unnecessarily change longstanding antitrust policy and law, particularly the Robinson-Patman Act and the Nonprofit Institutions Act as they apply to the pharmaceutical industry. The pace of Congress' consideration of health care legislation, however, appears to preclude such hearings.

Accordingly, I am submitting the attached Memorandum to the Subcommittee and to other Members for consideration during review of this legislation.

As discussed in greater detail in this Memorandum, because Section 2003(e) -- called "unitary pricing" -- seeks to require that identical discounts be provided by manufacturers for every purchase of a drug in this \$50 billion industry unless different discounts can be justified by reduced costs of production, I believe that the provision is unnecessary and unwise as a measure to address improper price discrimination in the pharmaceutical industry.

As a matter of health care policy, I believe that history shows that price control measures such as these rarely work and are often counterproductive. This provision could also threaten the world's most productive pharmaceutical research and development industry, and unwisely seeks to end the discounting of

VENABLE, BAETJER, HOWARD & CIVILETTI

Chairman Jack Brooks
 July 21, 1994
 Page 2

pharmaceuticals that President Clinton ironically cited as a model for containing health care costs in other areas. And finally, it may well lead to large, new paperwork intensive enforcement bureaucracies.

If you determine that it is appropriate, I request that this letter and the attached Memorandum be included with the records of the Subcommittee with regard to its consideration of this legislation.

Sincerely,


 Benjamin R. Civiletti 

VENABLE, BAETJER, HOWARD & CIVILETTI

STATEMENT OF BENJAMIN R. CIVILETTI
SUBMITTED TO THE SUBCOMMITTEE ON ECONOMIC AND COMMERCIAL LAW OF
THE
COMMITTEE ON THE JUDICIARY OF THE UNITED STATES HOUSE OF
REPRESENTATIVES
ON BEHALF OF G. D. SEARLE & CO. AND THE PHARMACEUTICAL
RESEARCH AND MANUFACTURERS OF AMERICA
July 21, 1994

This Statement is submitted on behalf of G. D. Searle & Co. and the Pharmaceutical Research and Manufacturer's Association (PhRMA) in connection with consideration by the Subcommittee of the "anti-discounting" provision of the Administration's proposed Health Security Act, Section 2003(e) of H.R. 3600.

This anti-discounting provision would significantly restrict the ability of pharmaceutical manufacturers to provide discounts in the sale of drugs, and could¹ eliminate the ability of these manufacturers to provide sharper discounts to purchasers that are capable of increasing sales of a product². I believe that this provision should not be enacted for four reasons.

First, the anti-discounting provision is ambiguous, unnecessary and would conflict with longstanding antitrust policy to promote competition, and longstanding antitrust law including the Robinson-Patman Act³. Furthermore, its enactment would unwisely fragment

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Congressional and Executive Branch jurisdiction and enforcement over antitrust policy, at least for the pharmaceutical industry.

Second, this provision is ill-advised public policy. Government price control efforts have consistently failed. In fact, the experience with pharmaceutical price control mechanisms established by the 1990 Omnibus Budget Reconciliation Act (OBRA) suggests that this anti-discount provision may actually raise pharmaceutical prices; not only for those consumers directly affected, but also for others. It is also ill-advised because Congress would displace the judgment of the marketplace and seek to favor one discrete set of purchasers and disadvantage others.

Third, despite the fact that the Administration proposed it, this approach would contradict a fundamental -- and correct -- market-based principle of its own health care policy: that costs can be controlled by consolidating purchasing power in large buyers, institutions and collectives, who can drive down prices and the costs of health care to workers. Experience has shown that managed care providers achieve these savings in large part by obtaining discounts from all of their providers: physicians, hospitals and pharmaceuticals.

And finally, enactment of this provision may well lead to exactly what all concerned about health care reform seek to avoid -- the creation of entirely new government enforcement bureaucracies and the likelihood of massive compliance reporting and paperwork.

VENABLE, BAETJER, HOWARD & CIVILETTI

I. The Anti-Discount Provision Is Inconsistent with
Established Antitrust Policy and Law.

Section 2003(e) of the proposed Health Security Act provides:

AGREEMENT TO GIVE EQUAL ACCESS TO DISCOUNTS. An Agreement under this subsection by a manufacturer of covered outpatient drugs shall require that every manufacturer offer drugs to every seller and every manufacturer and seller shall offer drugs to every purchaser with all rights and privileges offered or accorded on equal terms including purchase prices for similar volume purchases, rebates, free merchandise, samples and similar trade concessions. Nothing in this subsection prohibits the giving of a discount, on equal terms, that is justified by the economies or efficiencies realized by the manufacturer or seller resulting from:

- i) volume buying, including opportunities made available to all purchasers on equal terms to increase their volume buying through influencing physician prescribing practices or from agreements to place drugs on a formulary,
- ii) prompt payment, and
- iii) prompt delivery.

At the time this statement is submitted, to my knowledge this provision is contained only in the Administration's bill and in the version of it reported from the Ways and Means and the Labor and Education Committees of the House of Representatives.

While it appears similar to the Robinson-Patman Act, it differs fundamentally from that law in critical respects that would result in a reduction, and not an enhancement, of price competition in pharmaceuticals. The Robinson-Patman Act is a time-tested statute that deals adequately with the antitrust issues concerning the pharmaceutical industry.

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As you know, discrimination in the price of products -- including pharmaceuticals -- sold in the United States is generally governed by the Robinson-Patman Act Amendment to the Clayton Antitrust Act. The Robinson-Patman Act makes price discrimination illegal when the same kind of goods -- "commodities of like grade and quality" in the terms of the Act -- are sold to competing purchasers at different prices, and the effect of the discrimination is to "injure, destroy, or prevent competition" between and among the competing purchasers. But the Robinson-Patman Act, which has now been in effect for some 57 years, contains various exceptions and defenses that recognize that the purpose of the Act is to preserve and enhance competition, and not to impede it or create a windfall for any particular class of purchasers.

The Differences Between the Robinson-Patman Act and proposed Section 2003(e) of the Health Security Act, H.R. 3600

A comparison of Section 2003(e) with the Robinson-Patman Act reveals how little the two standards have in common. In fact, they would be in substantial conflict. Enactment of this anti-discount provision would have a negative impact on competition and impose confusion on the well-established body of law and procedure of the Robinson-Patman Act.

There are substantial ambiguities in the provision -- and more are likely when the Department of Health and Human Services and the courts interpret it superimposed upon the Robinson-Patman Act. Section 2003(e) is even ambiguous as to whether there are exceptions to allow different discounts. Even if it would, manufacturers would have to be

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willing to disclose and litigate their most proprietary information, i.e., their costs, prices and other sales and marketing information and prove that these different discounts are justified by reduced production and sales costs. In most instances, however, these discounts are provided not because manufacturing costs can be reduced but because sales can be increased⁴. According to its proponents, Section 2003(e) is intended to prevent manufacturers from giving discounts to increase sales. In addition, manufacturers will interpret this provision warily because of the significant penalties involved⁵. As a result, consumers who purchase from efficient sellers could be penalized and those who purchase from less efficient sellers at higher prices would be rewarded. That is an incentive to increase health care costs.

Another fundamental difference between the two provisions is that they treat competition differently. For example, Section 2003(e) would prohibit the charging of differing prices to various purchasers of a pharmaceutical even where the different purchasers do not themselves compete. The Robinson-Patman Act prohibits price discrimination only where such discrimination would have an adverse impact on competition between the two buyers. Section 2003(e) is an anti-discount provision, but in no sense of the term is it a "competition" bill.

Still another fundamental difference is that this anti-discount provision would effectively repeal the Nonprofit Institutions Act⁶, wherein Congress recognized the desirability of allowing nonprofit institutions to obtain the benefits of the lowest prices possible, and thus exempted purchases by nonprofit institutions, including hospitals and

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charitable institutions, of supplies for the institution's own use. That Act also allows discounts to qualifying non-profit HMOs. See De Modena v. Kaiser Foundation Health Plan, Inc., 743 F.2d 1388, 1393 (9th Cir. 1984), cert. denied, 469 U.S. 1229 (1985).

But Section 2003(e) provides no similar exemption for sales to nonprofit institutions. Thus, its passage would repeal the Nonprofit Institutions Act and would likely result in immediate, upward pressure on prices charged these institutions and ultimately consumers, the very opposite result from the goal of health care reform.

Section 2003(e) also differs from the Robinson-Patman Act by failing to include two other important defenses, defenses which help to ensure that the Act encourages rather than obstructs price competition.

Seemingly the only certainty is that if this provision were enacted, pharmaceutical manufacturers could look forward to years of litigation to determine what pricing restrictions Congress intended for pharmaceutical manufacturers by enacting this provision would be authorized by Robinson-Patman. Moreover, the incentive for manufacturers to devise cost efficiencies, savings and marketing strategies based upon differing customer needs and purchasing power would be dulled considerably if the same discount must apply to all customers.

Even more troublesome, however, is the absence from Section 2003(e) of perhaps the most fundamental defense available under the Robinson-Patman Act -- the meeting

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competition defense. Under Section 2(b) of the Robinson-Patman Act, sellers may discount their products or services to a customer if the level of discount is reasonably believed to be an attempt to meet the equally low price of a competitor. That defense reflects the belief that underlies American antitrust laws -- that robust competition in the marketplace is the best way to assure a vibrant economy. This is as true when the Government is policing the marketplace as when the Government is the purchaser. But there is no meeting competition defense under the Health Security Act.

Accordingly, a sale of pharmaceuticals that would have been legal under Robinson-Patman, may not be legal under Section 2003(e). As but one example, under the Robinson-Patman Act's meeting competition defense, a manufacturer can discount a drug to meet a competitor's price for a therapeutic equivalent, including a generic drug. Under the anti-discount provision, however, a manufacturer facing competition from a generic drug could be forced to either lower the price to all purchasers, or forego discounting to any.

And finally, there is no basis for concluding with confidence that the manufacturers' decision in response to enactment would be to lower the price for all and reduce costs accordingly. Rather, experience with government price controls in general, and OBRA '90 in particular, suggests that a manufacturer or seller will likely limit its discounting practices and/or raise its base price. While neither prior price control failures nor the experience under OBRA are conclusive proof that price inflation would occur if Section 2003(e) were enacted, the OBRA experience is the most relevant current economic information available concerning the likely economic effects of the proposal -- and it strongly supports the

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experience of other government price control efforts and the likelihood of a significant inflationary distortion of the marketplace as a result of these latest government efforts at favoritism to one class of purchaser.

Enactment of This Provision Would Create Overlapping and Inconsistent Antitrust Regulatory Schemes.

As disturbing as its substantive departures from current -- and sufficient -- price discrimination law would be, Section 2003(e) also is ill-advised because it would add a parallel, duplicative and (at this point) poorly-defined enforcement mechanism for the pharmaceutical industry but for no other industrial sector. While the Robinson-Patman Act is enforced by both the Department of Justice and the Federal Trade Commission, plus private plaintiffs, Section 2003(e) presumably would be enforced by the Department of Health and Human Services. Thus, at least each of these agencies would have authority to enforce overlapping and inconsistent statutes for this one segment of industry. The prospect of inconsistency is increased by the fact that HHS does not have the experience of the Department of Justice and the FTC in antitrust matters to determine if a prosecution would promote competition.

I do not believe that a new regulatory scheme is needed to ensure price competition in this industry. The Robinson-Patman Act has applied to pharmaceutical sales for 57 years. The percentage of health care costs attributable to pharmaceuticals in the United States is among the lowest in the world. The U.S. pharmaceutical industry is the world's leader in technology and innovation. The industry is highly competitive

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domestically and internationally. The share of total sales held by the 20 largest firms accounts for 75 percent of industry sales; all other firms account for 25 percent of the market. None of the major companies holds more than a 7.5 percent share of the market.⁷

There is no solid basis for concluding that the existing Robinson-Patman Act or the Nonprofit Institutions Act works properly in all other fields of manufacturing except pharmaceuticals. Furthermore, the application of Robinson-Patman principles is well understood by this Committee and by the Federal antitrust enforcement agencies. There is no reason why additional agencies are needed to interpret and apply novel provisions exclusively to the pharmaceutical industry.

In summary, the anti-discount proposal is a poor substitute for and bears no true similarity to the Robinson-Patman Act. As a result, the provision is likely to have the effect of and be implemented primarily as a price control measure, bringing with it the prospect of a new data-intensive enforcement bureaucracy and perhaps higher prices to consumers.

II. The Proposal Is Ill-Advised For Other Reasons.

"The cost containment provisions of the Administration's proposal might be useful in reducing taxpayer costs for the new benefits in Medicare, but they would add administrative complexity, could have substantial side effects, and might not reduce overall pharmaceutical costs."⁸

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Providing discounts to purchasers who can demand them or who can increase product sales, including Federal agencies, is a market-based means by which costs are increasingly controlled in the pharmaceutical industry, and also within the health care industry. Ironically, the success of HMOs and managed care groups in negotiating substantial discounts from drug companies by using their bargaining power was cited by President Clinton as a model of how consolidating bargaining power could drive down health care costs in other areas⁹. (Ironical, because the President's bill -- the anti-discount provision -- seeks to prevent the very discounts he lauds.)

Section 2003(e) is simply government price control that will likely benefit only one class of purchaser by making it unlawful for a manufacturer to cut prices to purchasers who can effectively demand them. History demonstrates that the efforts of our Federal government and other governments over hundreds of years to control prices by government intervention often have been counterproductive¹⁰. Some predict that price controls for the pharmaceutical industry would be consistent with that history. "If Congress adopts price controls on prescription drugs, it can expect results similar to the disastrous effects of price control on oil and natural gas."¹¹

Congress already has experience with the distortion and inflationary effects of a different, more limited form of pharmaceutical price control in the Omnibus Budget Reconciliation Act of 1990. As a result of that experience, in 1992, Congress specifically exempted the Veterans Administration and other Federal agencies from these price control provisions upon finding that the provision increased Federal budgetary outlays because it

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penalized price discounting to the Veterans Administration and other Federal agencies by requiring that the "best price," i.e., the deepest discount, be the basis for rebates to the Medicaid program. A recent HHS Report also acknowledges that these price controls raised Medicaid out-patient drug costs as well.¹²

This effect of OBRA '90 provisions on pharmaceutical prices was found by GAO, in Congressional oversight hearings,¹³ and by HHS.¹⁴ This history suggests that Section 2003(e) similarly would create substantial, government created market dislocations and may well result in an overall increase in pharmaceutical costs for the economy.

.The anti-discount provision would run counter to the current practice in the marketplace, and while all of its effects are not predictable, it would likely raise prices for consumers, or it will significantly impair the research and development investments by the United States pharmaceutical industry that have made it the most productive and competitive in the world.¹⁵ Or, it will both raise prices and reduce the R&D expenditures in the industry.

a. Discounting is an Important Means of Controlling Health Care Costs Today.

Cost-containment is the raison d'etre for managed care plans such as HMOs and PPOs, the driving forces behind the concept of managed competition. A critical element of their cost-containment efforts is their negotiation with suppliers of medical goods and services for discounted rates and other expenses. Both physicians and hospitals therefore

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regularly give discounted rates to managed care providers.¹⁶ Accordingly, discounting has become increasingly widely practiced throughout the managed health care field, not just for pharmaceuticals.¹⁷

The negotiation of discounted rates for pharmaceuticals is an important part of this cost-control strategy because although pharmaceutical costs since 1972 have accounted for only between 4.5 percent and 6.5 percent of total national health expenditures,¹⁸ expenditures on pharmaceuticals have almost doubled since 1988. Furthermore, pharmaceuticals have in the past -- and promise in the future -- to be a very cost-effective treatment alternative.¹⁹ According to the U.S. Office of Technology Assessment, "the potential for price competition is expanding rapidly as all kinds of health plans, both HMOs and indemnity plans embrace the concept of managed care pharmacy."²⁰

b. Price Controls for Pharmaceuticals: The Experience Under the 1990 OBRA.

Although "Economists have found that properly measured, pharmaceutical company profits are only slightly above the average for companies in all industries",²¹ Section 2003(e) is a government price control measure making it unlawful for a manufacturer to cut prices to those purchasers that can effectively demand them.

Section 2003(e) like previous governmental price control measures would benefit some purchasers and harm others for reasons that are not driven by economics or competition in the marketplace, but by government edict. It would harm HMOs, hospitals,

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and other large-scale purchasers, and benefit higher-cost retailers. It would affect pharmaceutical companies differently as well. It would harm those who compete for business on the basis of price discounting, and benefit those who do not. The economic incentive would move to price rigidity. In other words, the Federal Government would determine who would win and who would lose in the marketplace.

The 1990 OBRA provision substantially limited price competition for outpatient pharmaceuticals consumed by Medicaid patients, which constituted 13% of the overall pharmaceutical market. That legislation required drug manufacturers to rebate to HCFA the difference between the actual price charged to Medicaid recipients for outpatient drugs and the "best price" for the drug negotiated by the manufacturer with another party, usually a wholesaler. A mandatory minimum rebate of 12.5% was also established.

Congressional investigations soon revealed that the 1990 OBRA "best price" requirement had an immediate unintended inflationary effect. Many pharmaceutical manufacturers that had extended price discounts as a marketing incentive for certain large institutional customers (such as the VA, HMOs and hospitals) were forced to curtail or end these discounts because they could not afford to extend them to a much larger customer base. As a result, costs to the VA, HMOs and other purchasers of pharmaceuticals with substantial market power skyrocketed. In response, Congress in 1992 exempted the VA and other Federal entities from having their prices included in the Medicaid "best price" determinations.

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Recently released information by HHS reveals that this government price control effort not only raised prices for purchasers other than Medicaid, but ironically also increased costs for Medicaid, even after the rebates were deducted from its overall pharmaceutical costs. "In fact, the Medicaid drug program (net after rebate collections) has increased by about 30 percent from CY 1990 through CY 1992."²²

This experience with a limited restriction on discounts does not, of course, necessarily predict the outcome of a different and much broader limitation that would apply across the entire market. Its powerful effect on important pharmaceutical customers, such as the VA,²³ hospitals,²⁴ and HMOs,²⁵ however, provides a clear warning of the risks of an even broader government price controls intended to override the marketplace.

Technically, the 1990 OBRA provision covered only a relatively small portion (13%) of the pharmaceutical market. But its extraordinary impact on the rest of the market is powerful evidence of the extreme sensitivity and volatility of pharmaceutical discounts and the perversities created by government interference in the marketplace. According to the HHS Inspector General, approximately 90% of all drugs sold to bulk buyers had increased prices due to OBRA, nearly a third of which increased by more than 20%.²⁶

The U.S. Congress Office of Technology Assessment described the OBRA '90 situation as follows --

"The power of certain classes of purchasers to exact discounts was recognized by the framers of the 1990 Medicaid Rebate Law, which attempts to

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piggyback on the negotiating power of HMOs and large hospital groups to obtain the same discounts for Medicaid. The strategy may have backfired, however, because manufacturers become unwilling to give discounts to HMOs if, by so doing, they stand to lose the amount of the discount on 10 to 15 percent of the total market for outpatient prescription drugs. A coalition of large pharmaceutical purchasing groups recently called for the repeal of 'best price' provisions because of the elimination of such discounts after the Medicaid rebate law went into effect."²⁷

- c. Price Controls could both increase the costs of pharmaceuticals and reduce the level of research and development expended by the pharmaceutical industry.

Congress should think hard before it rejects both economic logic and recent -- and not so recent -- experience that suggest that price controls through a ban on negotiated price discounts could actually raise pharmaceutical prices to customers. The pharmaceutical industry has some unique features that make it particularly susceptible to the perversities of government price controls.²⁸ While some entities might initially benefit from this approach, others -- particularly the managed care providers -- would lose, and the overall effect may well be negative.

According to the U.S. Office of Technology Assessment, "the amount by which returns from developing a new drug exceed costs are modest, on average, and would be eliminated if the average price received for drugs sold worldwide were just 4.3 percent lower."²⁹

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But even if some pharmaceutical costs would decline, the anti-discount provision would have a significant negative impact on those drug companies that rely most on discounting, especially smaller firms -- and ultimately upon consumers. According to the Office of Technology Assessment, "...economic returns to the pharmaceutical industry as a whole exceeded returns to corporations in other industries by about 2 to 3 percentage points per year from 1976 to 1987, after adjusting for differences in risk among industries."³⁰ If pharmaceutical prices would decline, to avoid lower revenues firms would likely lower their current and significant investments in research and development.³¹ (Collectively, pharmaceutical companies currently spend almost \$11 billion annually on research and development, or approximately the same as the entire annual budget of the federal government's National Institutes of Health.³²)

Indeed, European and other foreign countries that have adopted strict price controls have experienced exactly that result. According to a September 1991 study by the U.S. International Trade Commission, similar foreign efforts at cost-containment price controls "often result[] in decreased levels of R&D spending"³³ In fact, "several countries that have implemented such programs have seen their pharmaceutical industries weaken and shift their production outside their borders."³⁴ "Virtually no innovative pharmaceutical products have been developed in Canada since the advent of stringent price controls in that nation in 1969. Countries like France and Austria, which have the toughest price restrictions on pharmaceuticals, also do the least research."³⁵

Because new pharmaceuticals often replace more expensive forms of medical treatment, such as surgery, a decrease in research and development would not only suppress the quality of future medical care but would also limit the extent to which pharmaceuticals replace more expensive treatment. Their experience in price controls sets an example to be avoided, not followed.

*Japan, Canada, and eleven of the twelve nations of the European Community (EC) all have some type of pharmaceutical price controls, yet spend proportionately more than the U.S. on drugs. In the one EC country without price controls, Denmark, spending on pharmaceuticals accounts for only 9.3% of national health spending -- a share that is lower than any other eleven EC nations.

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"The U. S. spends less on drugs not only in percentage terms but also in per-capita terms than any of the other six nations which comprise the "Group of Seven" (G7) with the world's biggest economies."³⁶

III. The Anti-Discounting Provision is Contrary to the Thrust of the Administration's Health Care Litigation.

"CONTROLLING PRESCRIPTION DRUG PRICES

"In the 1980's, the prices of prescription drug prices rose at quadruple the general rate of inflation. In recent years, several attempts have been made to control drug costs - often involving the use of buying clout to bring down prices.

"For example, HMOs and managed care groups are successfully using their bargaining power to negotiate substantial discounts from drug companies. Because they often control the brand of drugs prescribed by doctors, health plans have the power to drive down prices.

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"Under reform, with the addition of prescription drug coverage, Medicare will become the world's largest purchaser of drugs. And the Medicare program will use its negotiating power to get discounts from the pharmaceutical companies. In addition, with competing health plans trying to become more efficient, more and more buyers will use the same successful negotiating techniques."³⁷

Ironically, although the President's Health Security Report to the American People uses the example of the effects of increased bargaining power in the pharmaceutical industry as a model for cost containment in other areas of health care, the Administration's bill also seeks to preclude the discounting the Report lauds.

Congress' Office of Technology Assessment also concluded that --

"The most effective cost-control mechanisms are available to those private-sector plans that can control prescribing through formularies. Hospitals and staff-model HMOs have used this power to exact price discounts from manufacturers even when the manufacturers are single-source producers of a specific compound."³⁸

Today, large and small purchasers of pharmaceuticals have access to and follow as closely as Congress and the GAO an amazing amount of information concerning the prices, costs and margins of individual drug sales around the world. As a result, the terms of individual pharmaceutical sales are determined by powerful market forces. Greater consolidation of purchasing power and increased use of the vast new amounts of data will enable even more widespread discounts to consumers.

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The effects of an anti-discount provision are not as predictable or as well documented; but it is clear that enactment would significantly distort the current market direction under which an increasing percentage of consumers obtain lower pharmaceutical prices by aggregated purchasing power. Instead, the essential -- and correct -- thesis of the overall health care reform effort provides the evidence that its antithesis for pharmaceuticals may well increase prices and decrease research and development.

According to the Office of Technology Assessment --

"The success of some HMOs and hospitals in getting price concessions from manufacturers of single-source drugs (i.e., those with patent protection) attests to the potential for price competition to lower the cost of drugs to patients or their insurers."³⁰

IV. This Anti-Discounting Provision May Well Lead to Burdensome Paperwork Intensive Reporting and Record-Keeping Requirements.

The anti-discounting provision may well lead to new government data collection and reporting requirements for pharmaceutical manufacturers to collect, certify and submit detailed price and sales information to federal enforcement authorities. The Congressional Budget Office hints at the magnitude -- and the difficulty -- of the compliance effort.

"CBO's estimates assume that the federal government could enforce price restraints. But that is an open question. Many times in the past the federal government has tried to restrain price growth, usually with mixed results at best. The modern market is too complicated for a limited bureaucracy to track and control

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successfully. Prices in the drug market are especially complicated; drug prices vary in many dimensions (dosage, form, and packaging, to name only three), any one of which could be used to mask a price increase. Given the hundreds of drugs and manufacturers and the thousands of dosage and packaging forms, the federal agencies in charge of monitoring drug prices would have to rely on the basic compliance of the drug companies, as they do now for the Medicaid rebate. Such reliance often leads to incomplete compliance.⁴⁰ Apparently, it cannot be done currently under the Medicaid Rebate Program of OBRA 1990.⁴¹

V. Conclusion.

The anti-discount ban in the Administration's proposed bill cannot be justified as an antitrust measure. Indeed, it conflicts with and hopelessly complicates and confuses long-standing antitrust law and enforcement policy under the Robinson-Patman Act.

The ban is also ill-advised public policy that would lead either to increased prices for pharmaceuticals for all consumers (and especially those who pool their purchasing power to reduce their costs), or it will significantly reduce the investments in research and development that have made the U.S. pharmaceutical industry the world's leader.

And, by making illegal and subject to substantial penalties the provision of discounts to consumers who can now demand them, the provision would require an impossible bureaucracy, requiring massive paperwork reporting, to administer.

The provision should be deleted from any legislation concerning health care.

1. Section 2003(e) is quite ambiguous. The Congressional Budget Office apparently interprets Section 2003(e) to not apply when the terms of the sale are different: "Apparently, this equal-pricing provision may not prevent manufacturers from granting greater discounts to hospitals and health maintenance organizations than to retail pharmacies." "How Health Care Reform Affects Pharmaceutical Research and

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Development", A CBO Study, the Congressional Budget Office, Congress of the United States, June 1994, page 30.

On the other hand, the proponents of this anti-discount provision believe the opposite: "The non-discriminatory prices/provisions in the President's bill are designed to eliminate manufacturers' existing pricing practices which result in substantial, non-justified discounts being offered to limited segments of the pharmacy market, such as individual HMOs, hospitals, or mail-order pharmacies, as a means of securing market share." Statement of Ronald J. Ziegler, President and Chief Executive Officer of the National Association of Chain Drug Stores on Behalf of the Community Retail Pharmacy Health Care Reform Coalition Before the Health and the Environment Sub-committee of the House Energy and Commerce Committee, February 8, 1994.

In any event, the provision would introduce substantial ambiguities that may not be resolved for years and is unnecessary due to the Robinson-Patman Act, as discussed herein.

2. "The high level of R&D in this industry, together with relatively low production costs, has created a cost structure that encourages companies to seek ever-larger markets for their products, even if this requires substantial price discounts. The reason is that once a product is developed and approved for sale, it has already incurred R&D costs. Additional sales, even at deep discounts, serve to spread the R&D costs." "How Health Care Reform Affects Pharmaceutical Research and Development", A CBO Study, the Congressional Budget Office, Congress of the United States, June 1994, page ix.

3. 15 U.S.C. 13.

4. See endnote #2.

5. For example, according to the Congressional Budget Office, "the Secretary would be empowered to inspect the records of manufacturers and survey wholesalers, pharmacies, and institutional purchasers of drugs 'as necessary' to verify reported prices. [Health Security Act, Title II, Subtitle A, Sec. 2003(b)(3)(C)] Financial penalties of up to \$100,000 could be imposed on manufacturers who refuse to comply." "How Health Care Reform Affects Pharmaceutical Research and Development," A CBO Study, the Congressional Budget Office, Congress of the United States, June 1994, page 30.

6. 15 U.S.C. 13c

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7. IMS America. U.S. Pharmaceutical Market: Drug Store and Hospital Purchases.

8. "How Health Care Reform Affects Pharmaceutical Research and Development," A CBO Study, the Congressional Budget Office, Congress of the United States, June 1994, page 38.

9. "CONTROLLING PRESCRIPTION DRUG PRICES

"In the 1980's, the prices of prescription drug prices rose at quadruple the general rate of inflation. In recent years, several attempts have been made to control drug costs - often involving the use of buying clout to bring down prices.

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"Under reform, with the addition of prescription drug coverage, Medicare will become the world's largest purchaser of drugs. And the Medicare program will use its negotiating power to get discounts from the pharmaceutical companies. In addition, with competing health plans trying to become more efficient, more and more buyers will use the same successful negotiating techniques."

"Health Security: The President's Report to the American People", The White House Domestic Policy Council, October 1993, page 55.

10. "The federal government has tried often in the past to restrain price growth, usually with mixed results. A limited bureaucracy cannot successfully keep track of and control the modern market. Prices in the drug market are also very complicated; they vary in many dimensions (dosage, form, and packaging, to name only three), any one of which could be used to mask a price increase." "How Health Care Reform Affects Pharmaceutical Research and Development," A CBO Study, the Congressional Budget Office, Congress of the United States, June 1994, page 38

11. "Why Global Budgets and Price Controls Will Not Curb Health Costs," Edmund F. Hairlmaier, Heritage Foundation Reports, March 8, 1993.

12. Report to Congress: Medicaid Drug Rebate Program, Secretary of Health and Human Services, 1993 (although not released to the public until June, 1994). Page ES-2.

13. See, e.g., General Accounting Office, Medicaid: Changes in Drug Prices Paid by HMOs and Hospitals Since Enactment of Rebate Provisions (GAO/ED-91-139, Sept. 18,

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1991); Senate Rep. No. 102-401, *Veteran Health Care Act of 1992* P.L. 102-585, 2nd Sess. (1992); House Rep. No. 102-384, Part 2, (H.R. 2890); The Medicaid and Dept. of Veterans Affairs Drug Rebate, Amendments of 1992 (H.R. 2890).

14... Report to Congress: Medicaid Drug Rebate Program, Secretary of Health and Human Services, 1993 (although not released to the public until June, 1994) Page ES-2

15... "U.S. pharmaceutical companies are highly competitive in the international marketplace. The strength of the U.S. industry lies in its large R&D infrastructure and ability to produce new products of high quality. According to one recent survey, U.S. companies developed 113 of the 265 major globally prescribed drugs that were developed between January 1970 and May 1992." [citing Heinz Redwood, "New Drugs in the World Market," *The American Enterprise* (August 1993), pp. 72-80]. "How Health Care Reform Affects Pharmaceutical Research and Development," A CBO Study, the Congressional Budget Office, Congress of the United States, June 1994, page 12.

16... See Kralewski, John, et al., "Factors Related to the Provision of Hospital Discounts for HMO Inpatients," Health Services Research, 27:2 (June 1992), 133-53; U.S. Gen'l Acctg. Office, Managed Health Care, GAO/HRD-94-3, October 1993, p. 27; D. Garnick, et al., Services and Charges by PPO Physician for PPO and Indemnity Patients; An Episode of Care Comparison," Medical Care, 28:10, Oct. 1990, pp. 894-906.

17... "How Health Care Reform Affects Pharmaceutical Research and Development," A CBO Study, the Congressional Budget Office, Congress of the United States, June 1994, page x.

18... "How Health Care Reform Affects Pharmaceutical Research and Development," A CBO Study, the Congressional Budget Office, Congress of the United States, June 1994, page 3.

19... "The innovative medicines developed in this country -- while expensive -- enable the patient to avoid painful and even more costly surgery. Treating ulcers with H-2 antagonist drug therapy costs about \$900 a year. But the cost of ulcer surgery averages \$28,900." Murray Weidenbaum, "Drug price Rx with side effects", The Washington Times, May 1, 1993, page C1.

"Anecdotal evidence suggests that managed care providers use more pharmaceuticals than the average fee-for-service provider, even when demographic and other differences between the enrollees are taken into consideration. Managed care providers, such as group or staff health maintenance organizations, which are at financial for the costs of their patients' care, have a strong economic incentive to provide cost-

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effective treatments." "How Health Care Reform Affects Pharmaceutical Research and Development," A CBO Study, the Congressional Budget Office, Congress of the United States, June 1994, page 42.

20. U.S. Congress, Office of Technology Assessment, Pharmaceutical R&D: Costs, Risks and Rewards, OTA-H-522 (Washington, DC: U.S. Government Printing Office, February 1993).

21. "How Health Care Reform Affects Pharmaceutical Research and Development." A CBO Study, the Congressional Budget Office, Congress of the United States, June 1994, page 9.

22. Report to Congress: Medicaid Drug Rebate Program, Secretary of Health and Human Services, 1993 (although not released to the public until June, 1994). Page ES-2.

23. Prior to enactment of 1990 OBRA, the VA enjoyed perhaps the lowest pharmaceutical costs of any institutional purchaser in the country. Nevertheless, immediately after OBRA's enactment, drug prices negotiated by the VA rose by 14% in FY 1991, compared to 4% in pre-OBRA years. Senate Rep. No. 102-401, Veterans Health Care, 102nd Cong., 2nd Sess., 63 (1992), reprinted in 6 U.S. Code Cong'l and Adm News, 102nd Cong., 2nd Sess. at 4153.

By April 1992, the VA reported a \$92.6 million cost increase in FY 1991 from the 1990 OBRA alone. House Rep. 102-384, Part 2, The Medicaid Drug Rebate Amendments of 1992, 102nd Cong., 2d Sess., 10 (1992).

Companies that chose to continue discounts to the VA (among them Searle) paid a heavy price. For example, one company testified that its plan to continue extensive discounting to the VA would alone cost it more than \$100 million in Medicaid rebates in FY 1992. Prescription Drug Rebate Program, hearing before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce, 102d Cong., 2d Sess., 199 (1992) (Statement of R. Ingram, Group Vice President, Glaxo, Inc.).

24. Both the anecdotal and statistical data for hospitals confirmed a dramatic increase in costs due to pharmaceutical drug price increases. One study of 45 public hospitals and hospital systems found a 14% increase in costs in 1991 alone, costing \$130 million. Id. at 86 (Statement of M. Day, Executive Vice President, Parkland Mem. Hosp., Dallas, TX on behalf of the Nat'l Assn. of Public Hospitals). More than one-half of this hike was attributable to OBRA.

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25. HMOs also were adversely affected by OBRA. An informal survey by the Group Health Association of America found a net 6.1% increase in prices charged to member HMOs after discounting for inflation. Prescription Drug Rebate Program, at 151-53 (Statement of P. Penna, Group Health Cooperative of Puget Sound, on behalf of Group Health Ass'n of America, Inc.).

26. Dep't of Health and Human Services, Office of the Inspector General, Medicaid Drug Rebates: Impact of the Omnibus Budget Reconciliation Act of 1990 on Drug Expenditures Including Best Prices, 4 (1991).

27. U.S. Congress, Office of Technology Assessment, Pharmaceutical R&D: Costs, Risks and Rewards, OTA-H-522 (Washington, DC: U.S. Government Printing Office, February 1993), pages 262-3.

28. "It is well known that researchers in the pharmaceutical industry typically test thousands of chemicals in order to find one that passes all the clinical trials and is finally approved by the FDA. It is less well known that, on average, only 3 or 10 drugs approved by the FDA and brought to market sell sufficiently well to earn back the average investment in R&D for a new drug, which includes the cost of the pharmaceuticals that do not even make it to market.²⁵ Of these three, in the recent past, only one has been a principal source of industry income. Thus, a few very successful discoveries provide most of the income (see Figure 7)." "How Health Care Reform Affects Pharmaceutical Research and Development", A CBO Study, the Congressional Budget Office, Congress of the United States, June 1994, page ix.

[Footnote 25: Henry Grabowski and John Vernon, "A New Look at the Risks and Returns to Pharmaceutical R&D," *Management Science* (July 1990), P. 816. Analysts lack published data on costs by project; only the average cost is available. Thus, a drug might still be profitable even if sales do not cover the average amount spent on R&D, but it is unlikely to be very profitable unless its R&D costs are also very low.]

29. "How Health Care Reform Affects Pharmaceutical Research and Development," A CBO Study, the Congressional Budget Office, Congress of the United States, June 1994, page 45.

30. U.S. Congress, Office of Technology Assessment, Pharmaceutical R&D: Costs, Risks and Rewards, OTA-H-522 (Washington, DC: U.S. Government Printing Office, February 1993), page 2.

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31. "When price controls are imposed on any industry, they reduce returns on investment and thus reduce the ability of producers to fund research, development, or increased production. And they discourage outside investment in the controlled industry, as investors find that they can get a better return elsewhere." "Why Global Budgets and Price Controls Will Not Curb Health Costs," Edmund F. Hairlmaier, Heritage Foundation Reports, March 8, 1993.
32. "Why Global Budgets and Price Controls Will Not Curb Health Costs," Edmund F. Hairlmaier, Heritage Foundation Reports, March 8, 1993.
- 33... U.S. Int'l Trade Comm'n, Global Competitiveness of U.S. Advanced-Technology Manufacturing Industries: Pharmaceuticals, Rep. No. 332-302 to Comm. on Finance, U.S. Senate, USTIC Pub. No. 2438, at 10 (1991), reprinted in Health Care Reform and Prescription Drugs, at 191.
34. Id.
35. Murray Weidenbaum, "Drug price Rx with Side Effects," The Washington Times, May 1, 1993, page C1.
36. "Why Global Budgets and Price Controls Will Not Curb Health Costs," Edmund F. Hairlmaier, Heritage Foundation Reports, March 8, 1993.
37. "Health Security: The President's Report to the American People", The White House Domestic Policy Council, October 1993, page 55.
38. U.S. Congress, Office of Technology Assessment, Pharmaceutical R&D: Costs, Risks and Rewards, OTA-H-522 (Washington, DC: U.S. Government Printing Office, February 1993), page 262.
39. U.S. Congress, Office of Technology Assessment, Pharmaceutical R&D: Costs, Risks and Rewards, OTA-H-522 (Washington, DC: U.S. Government Printing Office, February 1993), page 29.
40. "How Health Care Reform Affects Pharmaceutical Research and Development," A CBO Study, the Congressional Budget Office, Congress of the United States, June 1994, page xv.

41. "In practice, isolating a price paid to the manufacturer for drugs sold at retail is difficult. Most retailers, primarily pharmacies, buy drugs through a wholesaler, but so do many institutional purchasers. About three-quarters of all drugs are distributed through independent wholesalers to both pharmacies and such institutional purchasers as hospitals. About 22 percent of the wholesalers' business consists of sales to hospitals. It is therefore difficult to calculate the average manufacturer retail price on the basis of the price charged to wholesalers. This calculation is currently done, however, for the Medicaid rebates, based on prices reported by the pharmaceutical companies." *Id.*, p. 30.



TESTIMONY SUBMITTED BY

MICHAEL R. LOSEY, SPHR

PRESIDENT & CEO

SOCIETY FOR HUMAN RESOURCE MANAGEMENT

ON

HEALTH CARE REFORM

THE COMMITTEE ON THE JUDICIARY

SUBCOMMITTEE ON ECONOMIC AND COMMERCIAL LAW

U.S. HOUSE OF REPRESENTATIVES

JUNE 22, 1994

Mr. Chairman, my name is Michael R. Losey, and I am President and CEO of the Society for Human Resource Management (SHRM). Thank you for the opportunity to present to the Subcommittee our views on the issue of malpractice reform.

As you may know, SHRM is the leading voice of the human resource profession, representing the interests of more than 60,000 professional and student members from around the world. SHRM provides its membership with education and information services, conferences and seminars, government and media representation, and publications that equip human resource professionals to become leaders and decision makers within their organizations. The Society is a founding member and Secretariat of the World Federation of Personnel Management Associations (WFPMA) which links human resource associations in 55 nations.

SHRM strongly feels that reform of the medical malpractice system would contribute significantly to the reduction of health care costs. This system should be reformed to avoid wasted energy and money spent on unnecessary "defensive" medicine and litigation.

According to the American Medical Association, between 1982 and 1989, professional liability premiums paid by health care providers exhibited the fastest annual percentage growth, over 15 percent, of all medical practice cost increases. In addition, the existing litigation system can lead providers to conduct many unnecessary tests as a "defensive" medicine against potential lawsuits.

SHRM believes that as part of malpractice reform Congress should encourage the creation of practice parameters as an affirmative defense. Practice parameters would establish guidelines for appropriate and inappropriate care and could serve as a legal basis for demonstrating that treatment was responsible and professional.

Reform of the system should also include caps on lawyer contingent fees. Although the contingent fee arrangement is useful for those unable to pay an hourly rate for an attorney, it is clear that if the patient is injured, the legal system should work to increase the patient's share of the ultimate recovery--not the attorney's. President Clinton has supported this concept in his health care reform package.

SHRM believes that contingent fee changes are essential to malpractice reform. However, the Clinton bill should go further by also capping punitive damages. SHRM understands that this type of cap is contemplated by the groups working on bipartisan reform plans, such as the Rowland/Bilirakis proposal pending in the House and the "Mainstream Group" plan to be introduced in the Senate Finance Committee.



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The House should act accordingly and not allow unlimited punitive damage awards to be available as a windfall to litigants. SHRM believes that if the health care reform system includes practice parameters, changes to the contingent fee structure, and caps on punitive damages there will be a significant positive impact on this nation's health care system.

A study by Lewin-VHI has shown that medical liability reform could save \$35.8 billion over five years. These savings would be achieved by reducing premium costs and decreasing the amount of defensive medicine practiced by health care providers. The money saved from malpractice reform could in turn be used to provide subsidies for the poor or health care coverage to the uninsured to help reach the President's goal of universal coverage.

SHRM appreciates the opportunity to share its views and the views of the human resource profession with the Subcommittee. We look forward to working with the Committee to ensure that this critical element of health care reform is included in the final legislation.



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